SUBSTANTIAL FUNDING CUTS TO EMERGENCY SHELTER AND HOUSING SERVICES THREATEN TO CRIPPLE SERVICES TO MILWAUKEE'S HOMELESS

An estimated **$585,000** in core Federal funding for Milwaukee's emergency shelter services has been cut. Funding has been reduced as follows:

- U.S. Department of Housing and Urban Development (HUD) Emergency Solutions Grant (ESG) funding was decreased by **21%.** The City of Milwaukee lost **$255,423** in ESG funds, and these funds were used **to support Milwaukee's frontline shelters, homeless prevention services and rapid rehousing programs.**
- The State's allocation of U.S. HUD ETH direct service funds has also been cut by **15%,** with the City of Milwaukee **losing $118,802 in housing support** ($25,957 in shelter and $92,845 in rapid re-housing, prevention, and outreach).
- City CDBG funds have decreased by **24%** in 2013, including **$108,000** in core homeless service grants and $200,000 in anticipated re-programming dollars not assigned as match dollars due to ESG funding cuts.
- In 2012, U.S. Department of Homeland Security's Emergency Food & Shelter Program (EFSP, formerly FEMA) was **cut by $103,311 or 34%** compared to 2010. In addition, there has been **no word** on an allocation for **2013**, leaving agencies guessing at whether these funds totaling nearly **$200,000** will come through at all.

These extensive funding cuts follow unprecedented **delays in governmental contract** issuance and cost reimbursement, which alone has significantly damaged the cash flow and financial resources of many homeless service providers. The second half of EFSP grant awards from 2012 finally became available in just the last week. The combined impact of extensive contract delays and unanticipated deep funding losses is crippling homeless services providers and resources:

- In an effort to maintain the current (and still insufficient) level of emergency shelter care bed capacity, agencies are being forced to close or scale back other related supportive services and **lay off case management and other direct service staff**. Direct client support – including food and basic supplies – are also being reduced or eliminated.
- Other essential sources of shelter funding (i.e., State Shelter Subsidy Grants) are increasingly in jeopardy due to staff and service reductions now being made.
- The loss of critical supportive services results in more frequent and increased shelter stays and longer waiting lists for homeless individuals with the greatest need – **more homeless people will end up on the streets and homelessness prevention will be more difficult to achieve.**

This significant loss of comes at a particularly challenging time in Milwaukee:

- Calls to IMPACT 2-1-1 for shelter care are now averaging **2,000 per month**, and these requests for emergency housing have increased each month and by nearly **18%** since 2012:

	Year 2007	Year 2008	Year 2009	Year 2010	Year 2011	Year 2012
Emergency Shelter Calls	**10,364**	**10,993**	**11,774**	**15,971**	**17,066**	**20,147**
Change from Prior Year	**NA**	**6.1%**	**7.1%**	**35.6%**	**6.9%**	**18.1%**
Change from Year 2007	**NA**	**6.1%**	**13.6%**	**54.1%**	**64.7%**	**94.4%**

- As evidenced in the January 2013 Point In Time (PIT) bi-annual survey of Milwaukee's homeless citizens, nearly **1,500** individuals were homeless the night of the survey, and from July 2012 to January 2013 increases of **4.7%** and **23.6%** were reported in the number of mentally ill and chronically homeless people.
- The link between homelessness and mental illness is well established and extensive, and the diminishment of homeless services will have a direct impact on Milwaukee County's Behavioral Health Division and their SMART System Re-Design efforts relating to community resources and service coordination improvements.

In October 2013, Milwaukee is set to launch a ***Coordinated Entry System*** for its continuum of homeless services, a central component of its **10-Year Plan to End Homelessness**. Under the leadership of United Way and with IMPACT 2-1-1 serving as the system's point of entry and managing agency, Coordinated Entry will change the community's homeless services systems and improve its efficiency and effectiveness with its emphasis on homelessness prevention, community-based case management, rapid re-housing, and housing access. These are all critical front-end resources to the Coordinated Entry system and are now vulnerable as a result of the substantial funding losses detailed. Coordinated Entry **NEEDS** front end services in order to reach its potential of being the most effective model of service delivery for individuals in a housing crisis.

Agency	Total 2013 Funding	% of Total Funding	Total Funding Loss
Cathedral Center	$ 160,890	6%	$ (70,233)
Community Advocates	$ 919,132	33%	$ (345,750)
Daystar	$ 45,152	2%	$ (5,739)
Guest House of Milwaukee	$ 378,253	14%	$ (77,313)
Hope House of Milwaukee	$ 242,326	9%	$ (35,298)
LaCausa	$ 47,112	2%	$ (6,023)
Legal Action of WI	$ 40,038	1%	$ (28,862)
My Home, Your Home	$ -	0%	$ (19,757)
Outreach Community Health Center	$ 43,386	2%	$ 23,629
Pathfinders	$ 80,676	3%	$ (15,168)
Salvation Army	$ 297,367	11%	$ (119,487)
Sojourner Family Peace Center	$ 322,125	12%	$ (57,590)
St. Aemilian-Lakeside	$ 23,546	1%	$ 5,446
Walker's Point Youth and Family Center	$ 115,055	4%	$ (24,786)
YWCA of Greater Milwaukee	$ 80,167	3%	$ (8,605)
Funding Source Totals	$ 2,795,225	100%	$ (785,536)
Minus $200,000 in re-programming			*$ (585,536)*

Shelter Task Force Member

SUMMARY		
FEMA cut - $		$ (103,311)
FEMA cut - %		-34%
ESG/ETH/CDBG cut - $		$ (691,421)
ESG/ETC/CDBG cut - %		-21%
City ESG cut - $		$ (255,423)
City ESG cut - %		-21%
State ETH cut - $		$ (127,998)
State ETH cut - %		-16%
City CDBG cut - $		$ (308,000)
City CDBG cut - %		-24%

Agency	Funding Source					
	ESG 2012	ESG 2013	ESG Change	State ETH 2012	State ETH 2013	ETH Change
Cathedral Center	$ 71,364	$ 56,580	$ (14,784)	$ 39,514	$ 37,433	$ (2,081)
Community Advocates	$ 305,771	$ 282,072	$ (23,699)	$ 456,736	$ 346,427	$ (110,309)
Daystar	$ 27,704	$ 21,965	$ (5,739)			
Guest House of Milwaukee	$ 177,728	$ 140,911	$ (36,817)	$ 139,046	$ 134,039	$ (5,007)
Hope House of Milwaukee	$ 96,491	$ 36,860	$ (59,631)	$ 39,514	$ 34,358	$ (5,156)
LaCausa	$ 29,075	$ 23,052	$ (6,023)			
Legal Action of WI	$ 38,900	$ 30,842	$ (8,058)	$ 30,000	$ 9,196	$ (20,804)
My Home, Your Home	$ -	$ -	$ -	$ 19,757	$ -	$ (19,757)
Outreach Community Health Center	$ -	$ -	$ -	$ 19,757	$ 43,386	$ 23,629
Pathfinders	$ 39,765	$ 31,527	$ (8,238)		$ 9,358	$ 9,358
Salvation Army	$ 254,527	$ 201,801	$ (52,726)	$ 19,757	$ 32,285	$ 12,528
Sojourner Family Peace Center	$ 89,802	$ 71,199	$ (18,603)	$ 19,757	$ 9,358	$ (10,399)
St. Aemilian-Lakeside	$ 18,100	$ 14,350	$ (3,750)	$ -	$ 9,196	$ 9,196
Walker's Point Youth and Family Center	$ 42,237	$ 33,487	$ (8,750)	$ -		
YWCA of Greater Milwaukee	$ 41,539	$ 32,934	$ (8,605)	$ -		
Funding Source Totals	$ 1,233,003	$ 977,580	$ (255,423)	$ 783,838	$ 665,036	$ (118,802)

	CDBG 2012	CDBG 2013	CDBG Change	FEMA 2010	FEMA 2012	FEMA Change
Cathedral Center	$ 38,250	$ 12,750	$ (25,500)	$ 81,995	$ 54,127	$ (27,868)
Community Advocates	$ 459,298	$ 262,198	$ (197,100)	$ 43,077	$ 28,435	$ (14,642)
Daystar	$ 23,187	$ 23,187	$ -	$ -	$ -	
Guest House of Milwaukee	$ 94,396	$ 73,996	$ (20,400)	$ 44,396	$ 29,307	$ (15,089)
Hope House of Milwaukee	$ 110,694	$ 150,694	$ 40,000	$ 30,925	$ 20,414	$ (10,511)
LaCausa	$ 24,060	$ 24,060	$ -	$ -	$ -	$ -
Legal Action of WI	$ -	$ -	$ -	$ -	$ -	$ -
My Home, Your Home	$ -	$ -	$ -	$ -	$ -	
Outreach Community Health Center	$ -	$ -	$ -	$ -	$ -	
Pathfinders	$ 37,580	$ 27,580	$ (10,000)	$ 18,499	$ 12,211	$ (6,288)
Salvation Army	$ 94,350	$ 31,450	$ (62,900)	$ 48,220	$ 31,831	$ (16,389)
Sojourner Family Peace Center	$ 251,066	$ 228,966	$ (22,100)	$ 19,090	$ 12,602	$ (6,488)
St. Aemilian-Lakeside	$ -	$ -	$ -	$ -	$ -	
Walker's Point Youth and Family Center	$ 79,845	$ 69,845	$ (10,000)	$ 17,759	$ 11,723	$ (6,036)
YWCA of Greater Milwaukee	$ 47,233	$ 47,233	$ -	$ -	$ -	$ -
Funding Source Totals	$ 1,259,959	$ 951,959	$ (308,000)	$ 303,961	$ 200,650	$ (103,311)

Shelter Task Force Member

WIsconsin Supports Everyone's Recovery Choice

Susan Gadacz, Director, BHD Community Services Branch
Shawn Green, Executive Director, Faith Partnership Network

What is WIser Choice?

- The public sector treatment and recovery support system for eligible Milwaukee County residents managed by the Behavioral Health Division, Community Services Branch
  - Age 18-59
  - Reside in Milwaukee County
  - Indigent or underinsured
  - Substance use disorder

History o f WIser Choice

- Federal Access to Recovery (ATR) Grant
- Received in 2004
- Partnership with DHS/DMHSAS
- One of 32 States
- Fee-for-Service (Voucher) Based Treatment System
- Serves 3,200 annually

Goals of WIser Choice

- Expand Capacity
- Support Client Choice
- Increase Faith-based Providers
- Focus on Recovery
  - Recovery support coordination;
  - Recovery support services; and,
  - Recovery check-ups.

Priority Populations

- Pregnant Women
- IV Drug Users
- Women and families
  - W-2 and BMCW
- Co-occurring Homeless
- Offenders Reentering from Prison
- Adult & Family Drug Treatment Court
- Veterans

WIser Choice Funding

- TANF
- ATR
- CA/TL
- MI-WISH
- MI-LINC
- IDP
- IVDU
- ADTC
- FDTC
- BMCW

$9.3 M/annually in the voucher network

How do people access services?

- Central Intake Units (CIU) screen for eligibility
  - IMPACT
    - General population
      - Mobile screening at Genesis Detox
      - BHD
  - UCC
    - Hispanic, bilingual, monolingual population
  - M&S Clinical Services
    - General population
      - Mobile screening at Genesis detox
  - Justice Point
    - DTC clients & DP's
  - WCS
    - Criminal justice

Clinical Levels of Care

- Bio-Med Residential
  - Highest level, co-occurring, medically compromised
- Medically Monitored Residential
- Transitional Residential
  - Outpatient Plus
- Day Treatment
- Outpatient

What Is Recovery Support Coordination?

- Recovery Support Coordination is a strength-based case management model that provides the framework for an individualized plan of care to be developed for each participant. The purpose of recovery support coordination is to assist clients to establish their own path to recovery and ensure the client's wellbeing beyond the provision of formal services.

Recovery Support Services

- Daily Living Skills
- Domestic Violence Services
- Education/Academic Skills Development
- Housing Assistance
- Parenting Assistance
- Parenting Classes
- Spiritual Support

Recovery Support Services, cont.

- Anger Management Services
- Bridge Housing
- Room and Board
- Community Employment
- Childcare
- Peer Mentoring services

WIser Choice Outcomes

- One of the top 3 performing sites in the Nation
- Exceeds Relative Change in 80% of the outcomes collected
- Recovery Check-up is also at 80% follow up rate

Questions

Contact Information

Janet Fleege

WIser Choice Project Director

414-257-6925

E-mail: Janet.Fleege@milwcnty.com

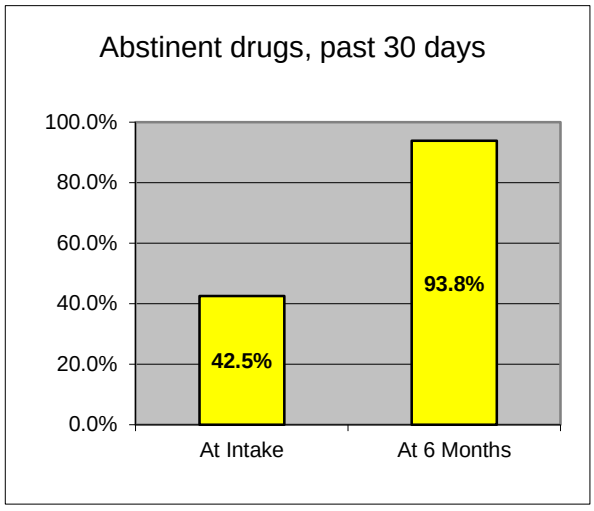
Milwaukee WIser Choice

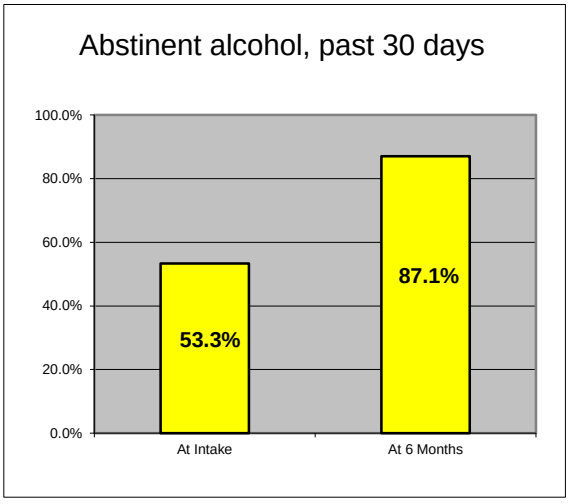
WIser Choice, ATR-3 Years 1-2, NOMS, Change Intake to 6 Months After
Sample: WIser Intakes 10-1-10 to 9-30-12 excluding IDP, ADTC, and MiLINC (N=3916)

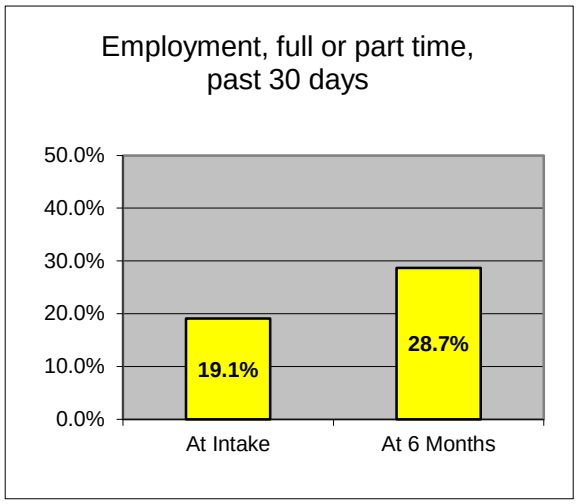
NOMs CATEGORY (with alternatives)	At Intake	At 6 Months	Absolute Change	Relative Change	*Rel. Chg. National**
Abstinent Alcohol 30 Days	53.3%	87.1%	+33.8%	**+63.4%**	*+17.3%*
Abstinent Drugs 30 Days	42.5%	93.8%	+51.3%	**+120.7%**	*+20.4%*
Permanent Housing	67.9%	66.1%	-1.8%	**-2.7%**	*+29.8%*
Employed, Full- or Part-time[a]	19.1%	28.7%	+9.6%	**+50.3%**	*+47.7%*
Employed OR Enrolled School/Training	25.2%	40.0%	+14.8%	**+58.7%**	*+49.6%*
Arrested Past 30 Days	33.4%	6.4%	-27.0%	**-80.8%**	*-52.7%*
Arrested Past 6 Months	35.8%	12.6%	-23.2%	**-64.8%**	*N.A.*
No Supportive Family, Friend or Group	15.2%	10.3%	-4.9%	**-32.2%**	*-0.8%*

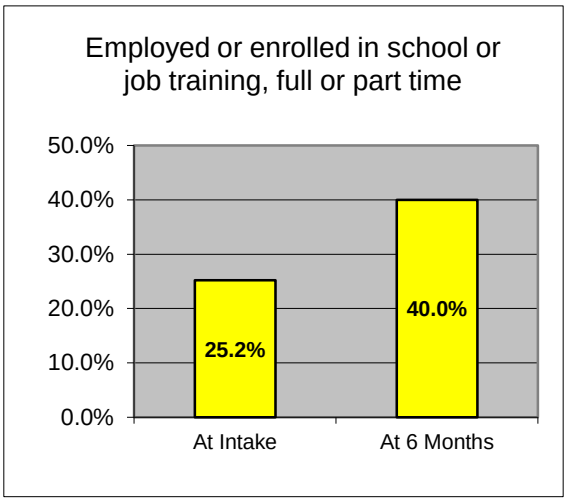
*Relative Change National from SAIS ATR-3 downloads 8-12-12 (Employment, Arrests) and 7-8-2013 (All Others)

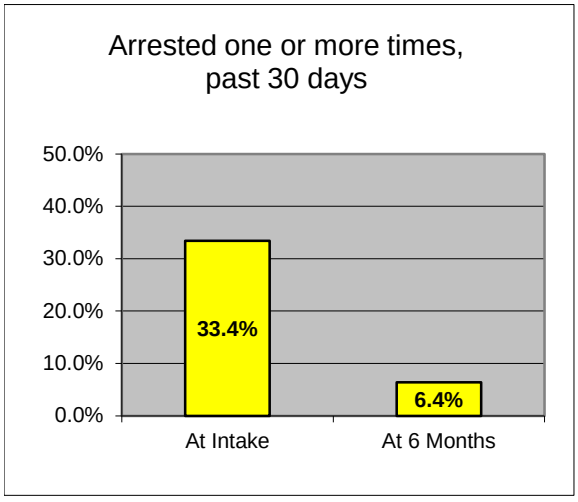
Milwaukee WIser Choice
Charts, Intake vs. 6 Month

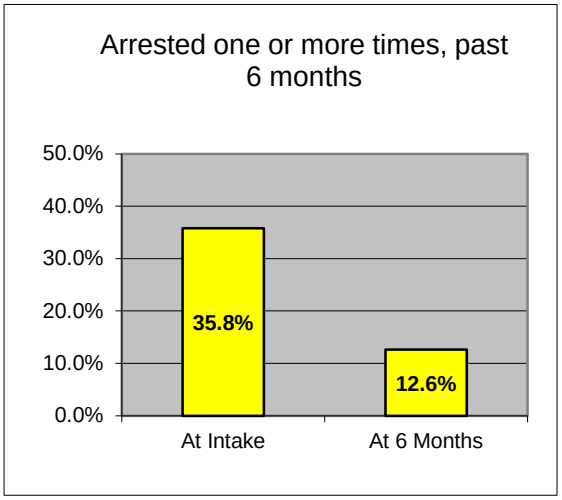


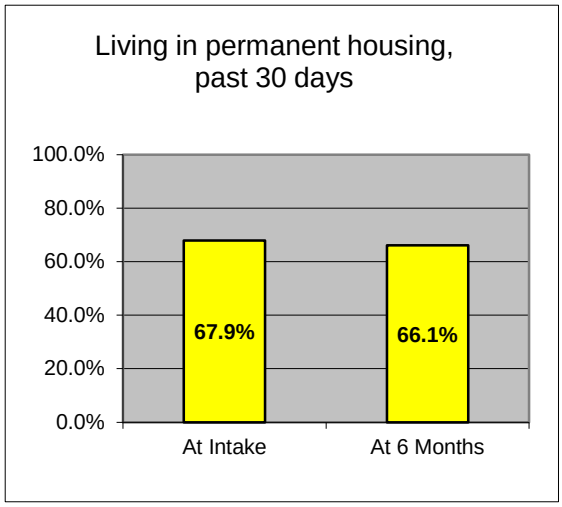


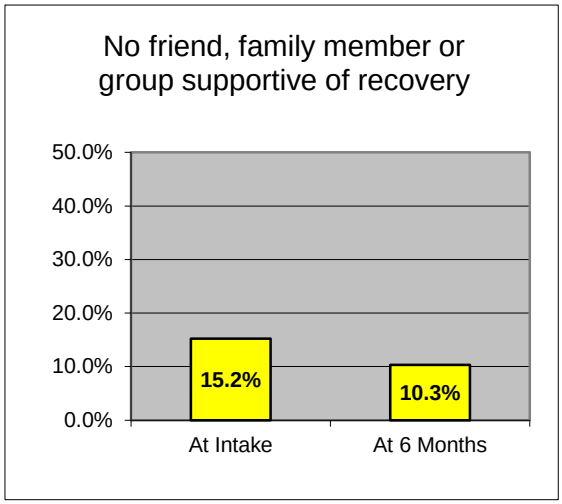

Employment, full or part time, past 30 days
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
19.1%
28.7%
At Intake
At 6 Months


Employed or enrolled in school or job training, full or part time
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
25.2%
40.0%
At Intake
At 6 Months


Arrested one or more times, past 30 days
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
33.4%
6.4%
At Intake
At 6 Months


Arrested one or more times, past 6 months
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
35.8%
12.6%
At Intake
At 6 Months


Living in permanent housing, past 30 days
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
67.9%
66.1%
At Intake
At 6 Months


No friend, family member or group supportive of recovery
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
15.2%
10.3%
At Intake
At 6 Months

MEMORANDUM

Date: August 26, 2013

To: Supervisor Willie Johnson Jr, Co-Chairman, Committee on Finance, Personnel and Audit
Supervisor David Cullen, Co-Chairman, Committee on Finance, Personnel and Audit
Supervisor Peggy Romo West, Chairwoman, Committee on Health and Human Needs

From: Maria Ledger, Director, Department of Family Care

Subject: Information Only Report with respect to operations of Milwaukee County Department of Family Care in Racine and Kenosha.

This memorandum is a requested update on the Milwaukee County Department of Family Care (MCDFC) operations in Racine and Kenosha. MCDFC began offering the Family Care benefit in Racine and Kenosha County on May 1st, 2012.

Statewide Trends in Long term Care Delivery Systems

MCDFC has been very mindful of the statewide trends towards a more regional approach to the delivery of long-term care services. In January of 2012, there were nine Family Care Managed Care Organizations (MCO's) in Wisconsin. Currently, there are eight and by January 1st 2014, the number of MCOs' offering the Family Care benefit in Wisconsin will decrease to seven. Of those seven MCOs that remain operational, five have expanded operations beyond their original boundaries. The two MCOs that have ceased operations did not choose to expand. The MCOs that are replacing these two organizations are already contracted with the State and are expanding to new geographic service regions.

This move towards regionalization and consolidation is why MCDFC sought Board approval to expand operations to other counties in order to help insure the sustainability of the program in Milwaukee.

Enrollments in Racine/Kenosha

Since May of last year, MCDFC has served more than 100 members in Racine and Kenosha. Our current census is 81 members with the majority of our disenrollments occurring due to death.

We have 30 members with intellectual disabilities, 20 members who are frail elders and 31 members who are physically disabled. The majority of our Racine/Kenosha members reside in community settings. Only 2 members reside in Nursing Homes.

While MCDFC has been establishing its operations in Racine and Kenosha, we have been insistent that MCDFC must not experience any decline operationally, qualitatively or fiscally.

Provider Network

In Milwaukee, we have grown our provider network to more than 1,000 community agencies. We have provided $2.4 million in provider rate increases ranging from 4% to 5% for day services, employment services and transportation, as well as a wage increase to supportive home care workers employed by our two Supportive Home Care Employment Service Agencies.

Member Satisfaction

Our members continue to report high levels of satisfactions with the program and the services they receive. Throughout 2012, 1,233 members responded to our member satisfaction survey and provided the following specific information:

- 93% of members are happy with the quality of the services they receive;
- 92% of members would recommend the MCDFC MCO to a friend;
- 94% of members receive help from their CM/RN when they need it;
- 95% of members report their CM and RN listen to their concerns.

The State's Quality Audit

The State's External Quality Review Entity, Metastar, has also made note of the quality of our program and the services we provide.

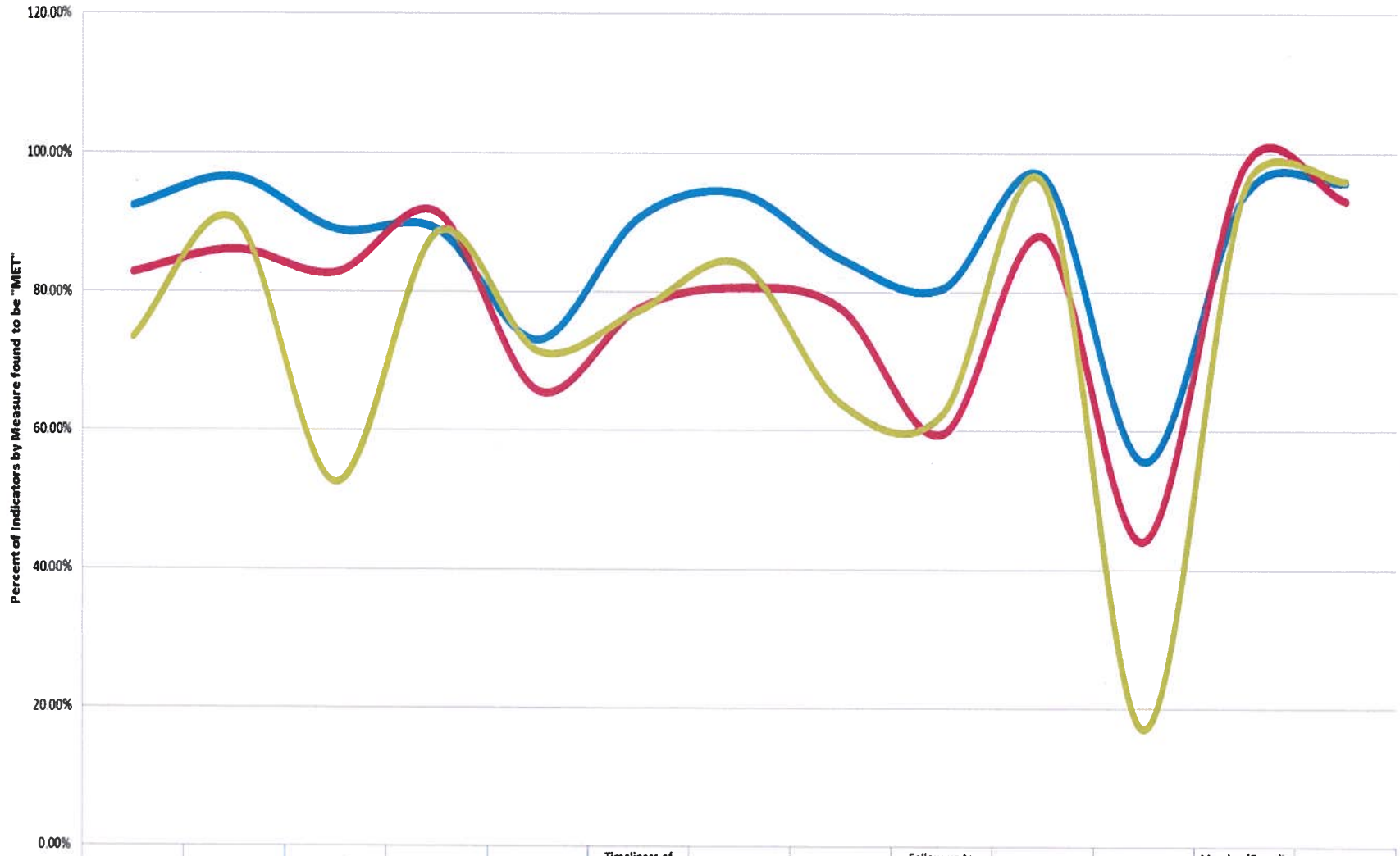
In the Care Management Record Review of our most recent audit, Metastar found the following:

- 11 of the 13 Quality Indicators demonstrated improvement
- 7 of the 13 Indicators had a "Met" average in the 90% range.
- The overall average climbed to 90% for 2012-2013

Additionally, during the **Quality Compliance Review** portion, as an MCO we were found to have made significant progress since our 2011-2012 review and have:

- Improved consistency of practice across CMU's
- Improved communication, monitoring, and mentoring for teams

MCDFC AQR Care Management Record Review Results 2010 - 2013



	Comprensiveness of Assessment	Re-Assessment Done when Indicated	Comprensiveness of Most Recent MCP	Timeless of Most Recent MCP	Plan Updated for Significant Changes	Timeliness of Service Authorization Decisions	Risk Related to Member Choice Addressed	Timely Coordination of Services	Follow-up to Ensure that Services are Effective	Identified Needs are Addressed	Notice of Action issued in a timely manner	Member/Guardian/Family/Informal Supports Included	SDS Options Offered
2012-2013	92.37%	96.49%	88.98%	88.98%	73.08%	90.68%	94.19%	84.75%	80.51%	96.61%	55.56%	94.07%	95.76%
2011-2012	82.76%	86.09%	82.76%	91.38%	65.71%	77.59%	80.65%	77.59%	59.48%	87.93%	44.07%	98.28%	93.10%
2010-2011	73.42%	90.41%	52.53%	88.61%	71.43%	77.27%	84.09%	63.92%	62.42%	95.57%	17%	94.94%	96%

Enrollment

The MCDFC has budgeted for a "flat" enrollment for 2014 in Milwaukee County. While one always hopes for growth in enrollment, we have worked hard to avoid the declines other MCO's have seen in their own enrollment.

Potential members in Milwaukee must now choose between two Family Care MCOs, two Partnership MCOs and IRIS. We have managed to maintain our enrollment by providing high quality services, meaningful choice for members and by making sure that we let the public know who we are and what we do.

Our marketing efforts, detailed below, are a critical part of maintaining our enrollment by informing current and potential members of the benefits of this program.

Sponsorships	**Number of People Reached**
Broadway Theatre Center - Assisted in purchasing Ramp and Assisted Listening Devices.	19,000
Independence First - Night for Independence	500
Racine County Special Needs Resource Fair	75
Senior Companion Program – Racine	350
Marcus Center for the Performing Arts – Purchased Assisted Listening Devices	280,000
Set Ministry - Setforth Breakfast	350
WMCS 1290 Christmas Family Feast	9000
Community Healing Music Presentations	400
MADDSA Caregiver Appreciation luncheon	250
Milwaukee Aging Consortium Caregiver Conference	350
Total:	**310,275**

Resource/Information Fairs	**Number of People Reached**
Wisconsin Aging Consortium Caregiver Educational Event	500
50 Plus Senior Resource Fair	780
Booth at Festa Italiana	7,300
Killarney Kourt – Racine	80
1290 Health and Wellness Fair	450
Seniorfest - Serb Hall - 30th year event	1,000
Milwaukee County Resource Fair	1,500
State Fair - Hosted Resource Booth	13,500
Heart of the Matter Resource Fair Information Booth	125
Senior Empowerment Resource Fair – Racine	250
Super Senior Friday	300
Azura Dementia Conference	50
Veterans Place Resource Fair	75
St Monica's Senior Resource Fair – Racine	350
St Rita's Parrish	150
Kenosha County Fair	1,200
Health and Wellness Fair – Sturdevant	75
Veterans Day at Milwaukee County Zoo	500
Senior Day at Summer Fest	350
Total:	**28,535**

Advertising	Number of People Reached
Poster Board Advertising	14,569,118
Transit Shelters	3,436,084
Interior Cards	23,460
Med Center Display	49,500
1290 Healthy Lifestyle Spot	28,000
WRIT Radio Community Service Ads	306,400
WKKV Radio Community Service Ads	138,200
WMIL Radio Community Service Ads	277,100
WOKY Radio Community Service Ads	31,300
Total:	**18,859,162**

Lastly, continuing from 2012 our financials demonstrate a strong fiscal performance in the current year. The State Department of Health Services complimented our Chief Financial Officer on both the results and presentation of our financial statements stating, "You've done a great job there!"

The financial results for Racine and Kenosha Counties are a net income of $152,566 and a net income of $3,140,141 for Milwaukee County. For the Committee on Finance, Audit and Personnel's convenience the financial reporting summaries of the first six months of 2013 for Racine and Kenosha Counties, Milwaukee County and on a consolidated basis are provided below.

MCDFC-MCO Income Statement
For the period of January 1 thru June 30, 2013

Racine and Kenosha Counties

	1/1/2013 - 6/30/13 Estimated Actual	1/1/2013 - 6/30/13 Budget
Revenues		
Capitation Revenues	$1,026,122	$1,604,415
Member Obligation Revenues	$80,158	$716,343
Other Revenues		$0
Total Revenues	**$1,106,281**	**$2,320,758**
Expenses		
Member Service Expenses	$886,750	$1,626,207
Administrative Expenses:		
---Labor & Fringes		$0
---Vendor Contracts	$66,964	$131,571
---Cross Charges/internal transfers		$0
---Other expenses (supplies, mileage, etc.)		$48,727
---Est. contribution to reserve		
Total Expenses	**$953,715**	**$1,806,506**
Net Surplus/(Deficit)	**$152,566**	**$514,252**

June 2013 Enrollment	
Nursing Home (Comprehensive):	
59 and Under	40
60 and Over	28
Non-Nursing Home (Intermediate):	
59 and Under	0
60 and Over	0
Total Members Served	69

MCDFC-MCO Income Statement
For the period of January 1 thru June 30, 2013

Milwaukee County

	1/1/2013 - 6/30/13 Estimated Actual	1/1/2013 - 6/30/13 Budget
Revenues		
Capitation Revenues	$125,600,206	$125,369,122
Member Obligation Revenues	$15,442,823	$14,652,878
Other Revenues	$1,247,168	$432,815
Total Revenues	**$142,290,196**	**$140,454,815**
	$142,290,196	
Expenses		
Member Service Expenses	$132,370,717	$132,625,923
Administrative Expenses:		
---Labor & Fringes	$3,096,736	$3,515,383
---Vendor Contracts	$2,120,540	$2,499,283
---Cross Charges/internal transfers	$663,426	$651,774
---Other expenses (supplies, mileage, etc.)	$898,637	$1,327,467
---Est. contribution to reserve	$0	$0
Total Expenses	**$139,150,056**	**$140,619,830**
Net Surplus/(Deficit)	**$3,140,141**	**($165,015)**

June 2013 Enrollment	
Nursing Home (Comprehensive):	
59 and Under	**1,880**
60 and Over	**6,008**
Non-Nursing Home (Intermediate):	
59 and Under	**69**
60 and Over	**35**
Total Members Served	**7,991**

MCDFC-MCO Income Statement
For the period of January 1 thru June 30, 2013

Consolidated

	1/1/2013 - 6/30/13 Estimated Actual	1/1/2013 - 6/30/13 Budget
Revenues		
Capitation Revenues	$126,626,328	$126,973,536
Member Obligation Revenues	$15,522,981	$15,369,221
Other Revenues	$1,247,168	$432,815
Total Revenues	**$143,396,477**	**$142,775,573**
Expenses		
Member Service Expenses	$133,257,467	$134,252,130
Administrative Expenses:		
---Labor & Fringes	$3,096,736	$3,515,383
---Vendor Contracts	$2,187,504	$2,630,854
---Cross Charges/internal transfers	$663,426	$651,774
---Other expenses (supplies, mileage, etc.)	$898,637	$1,376,194
---Est. contribution to reserve	$0	$0
Total Expenses	**$140,103,770**	**$142,426,335**
Net Surplus/(Deficit)	**$3,292,707**	**$349,237**

June 2013 Enrollment	
Nursing Home (Comprehensive):	
59 and Under	1,920
60 and Over	6,036
Non-Nursing Home (Intermediate):	
59 and Under	69
60 and Over	35
Total Members Served	8,060

Cc: County Executive Chris Abele
Chairwoman Marina Dimitrijevic, Milwaukee County Board of Supervisors
Supervisor James Schmitt, Milwaukee County Board of Supervisors
Amber Moreen, Chief of Staff, Office of the County Executive
Raisa Koltun, Director of Legislative Affairs, Office of the County Executive
Kelly Bablitch, Chief of Staff, Milwaukee County Board of Supervisors
Steve Cady, Fiscal and Budget Analyst, Milwaukee County Board of Supervisors
Jodi Mapp, Committee Clerk, Milwaukee County Board of Supervisors
Janelle Jensen, Committee Clerk, Milwaukee County Board of Supervisors
Jim Hodson, Chief Financial Officer, MCDFC

COUNTY OF MILWAUKEE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
INTER-OFFICE COMMUNICATION

DATE: August 22, 2013

TO: Supervisor Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by: B. Thomas Wanta, Administrator, Delinquency and Court Services Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Providing Notice of the Youth Sports Authority Award Recommendations and Approval for the Fiscal Agent to Distribute Funds**

Policy Issue

The Milwaukee County Board requires that recommendations from the Youth Sports Authority Board for the distribution of funds be approved by the County Board of Supervisors. In accordance with the policies associated with the Youth Sports Authority, the Director, Department of Health and Human Services (DHHS), is requesting authorization on behalf of Community Advocates, the fiscal agent, to make awards for fall 2013 using the approved Youth Sports Authority funds.

Background

In November 1999, the Milwaukee County Board of Supervisors adopted a provision as part of the 2000 County Budget that provided $200,000 for establishment of the Milwaukee County Youth Sports Authority. The Sports Authority was to be governed by a seven-member Board that would review requests for funding of youth sports programs from community organizations and the Milwaukee Foundation was determined to be the fiscal agent. The program, originally housed in the County Health Programs Division (CHP), was aimed at promoting athletic activities for at-risk youth that would encourage healthier lifestyles and positive interpersonal behavior. Later that year, the County Board also approved operational policies to govern the distribution of Sports Authority funds. Program funding levels and fiscal agents have changed through the years but the policies have remained the same. The 2013 allocation of $100,000 includes an administrative fiscal agent reimbursement not to exceed $8,000. Sports Authority funding may be used for the development of sports activities for youth, including expenses associated with clinics and training for coaches, stipends for youth coaches, CPR and First-Aid training for volunteers, equipment, health checkups, leadership and self-discipline activities, referees, nutritious food and registration fees. Funds may support a wide variety of sports for youth ages 6-18 who live in Milwaukee County, including baseball,

basketball, football, golf, soccer, softball, swimming, gymnastics, tennis, track, volleyball, wrestling, boxing, adaptive and other sports.

Year	Funding Level	Fiscal Agent
2000	$ 200,000	Milwaukee Foundation
2001	$ 200,000	Milwaukee Foundation
2002	$ 200,000	Milwaukee Foundation
2003	$ 200,000	Milwaukee Foundation/ Planning Council
2004*	$ 150,000	Planning Council
2005	$ 150,000	Planning Council
2006	$ 150,000	Planning Council
2007	$ 145,000	Planning Council
2008	$ 200,000	Planning Council
2009	$ 200,000	Planning Council/ Fighting Back
2010	$ -	Fighting Back/ Jewish Family Services
2011	$ 100,000	Jewish Family Services
2012	$ 100,000	Jewish Family Services
2013	$ 100,000	Community Advocates

**2004 funding was transferred from CHP to the Delinquency and Court Services Division*

Fall 2013 Award Recommendations

The Youth Sports Authority Board met on July 10, 2013 to review applications for conformity to the Sports Authority's adopted policies and goals and to make recommendations regarding funding for the proposals. Over 50 applications were submitted from local agencies. At that meeting, the Board recommended that 25 organizations be awarded grant funding in the amounts indicated below. The 25 recommended applicants will serve over 5,600 youth in sports programming.

The following table summarizes the community-based youth programs recommended by the Sports Authority Board for funding for fall 2013:

	Organizations	**Recommended Amount**
1	Ace Boxing Club	$ 4,000
2	AGAPE Community Center	$ 3,200
3	Al Morland Productions, LTD	$ 4,000
4	Alexander Hamilton Jr. Wildcat Football Foundation, Inc.	$ 4,000
5	City Kids Wrestling Club, Inc	$ 4,000
6	COA Youth & Family Center	$ 2,148
7	Dr. Martin Luther King Community Center	$ 4,000
8	Epic Center Community Organization	$ 3,200
9	Golda Meir	$ 4,000
10	Images of Us Sports (IOU)	$ 3,200
11	Journey House, Inc	$ 4,000

12	Milwaukee Christian Center	$	2,000
13	Midwest Kickers	$	4,000
14	Milwaukee Jr. Cougar Football Team	$	4,000
15	Milwaukee Piranha Swim Club	$	3,000
16	Milwaukee Tennis & Education Foundation	$	4,000
17	Milwaukee Urban Soccer Collaborative	$	4,000
18	Neu-Life Community Development	$	4,000
19	New Hope Hmong Ministries	$	3,000
20	Playworks Education Energized	$	4,000
21	Running Rebels	$	5,000
22	Silver Spring Neighborhood Center	$	4,000
23	Summit Educational Association, Inc.	$	4,000
24	Unity in Motion	$	3,000
25	Wings of Glory	$	4,000
	TOTAL	$	91,748

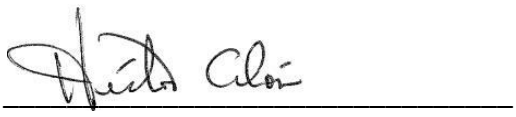
Fiscal Effect

The 2013 DCSD Budget includes sufficient funding for the recommendations listed above for the Youth Sports Authority program. There is no tax levy effect. A fiscal note form is attached.

Recommendation

It is recommended that the County Board of Supervisors authorize the distribution of 2013 Sports Authority funds to the community organizations identified herein and in the amounts specified above.

Respectfully Submitted,



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Kelly Bablich, Chief of Staff, County Board
Don Tyler, Director, DAS
Josh Fudge, Interim Fiscal and Budget Administrator - DAS

CJ Pahl, Assistant Fiscal and Budget Administrator - DAS
Matt Fortmann, Fiscal & Management Analyst - DAS
Martin Weddle, Analyst, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff

File No.
(Journal,)

(ITEM) From the Director, Department of Health and Human Services (DHHS), requesting authorization for the Youth Sports Authority Board and its fiscal agent, Community Advocates, to distribute Youth Sports Authority funds, by recommending adoption of the following:

A RESOLUTION

WHEREAS, in accordance with the policies associated with the Youth Sports Authority, the Director of the Department of Health and Human Services (DHHS) is requesting authorization for the Youth Sports Authority Board and its fiscal agent, Community Advocates, to distribute Youth Sports Authority funds; and

WHEREAS, a total of $100,000 was appropriated for the Youth Sports Authority in the 2013 Adopted Budget of the Delinquency and Court Services Division (DCSD); and

WHEREAS, over 50 application requests for funding were submitted by local agencies; and

WHEREAS, the Youth Sports Authority Board met on July 10, 2013 to review applications for conformity to the Sports Authority's adopted policies and goals and to make recommendations regarding funding for the proposals; and

WHEREAS, the Youth Sports Authority Board recommended that 25 organizations, who in 2013 will serve over 5,600 youth through sports programming, be awarded grant funding; now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors does hereby authorize and direct the Youth Sports Authority Board and its fiscal agent, Community Advocates, to distribute Youth Sports Authority funds to the agencies and in the amounts listed below:

	Organizations	**Recommended Amount**
1	Ace Boxing Club	$ 4,000.00
2	AGAPE Community Center	$ 3,200.00
3	Al Morland Productions, LTD	$ 4,000.00
4	Alexander Hamilton Jr. Wildcat Football Foundation, Inc.	$ 4,000.00
5	City Kids Wrestling Club, Inc	$ 4,000.00
6	COA Youth & Family Center	$ 2,148.00
7	Dr. Martin Luther King Community Center	$ 4,000.00
8	Epic Center Community Organization	$ 3,200.00
9	Gloda Meir	$ 4,000.00

10	Images of Us Sports (IOU)	$ 3,200.00
11	Journey House, Inc	$ 4,000.00
12	Milwaukee Christian Center	$ 2,000.00
13	Midwest Kickers	$ 4,000.00
14	Milwaukee Jr. Couger Football Team	$ 4,000.00
15	Milwaukee Piranha Swim Club	$ 3,000.00
16	Milwaukee Tennis & Education Foundation	$ 4,000.00
17	Milwaukee Urban Soccer Collaborative	$ 4,000.00
18	Neu-Life Community Development	$ 4,000.00
19	New Hope Hmong Ministries	$ 3,000.00
20	Playworks Education Energized	$ 4,000.00
21	Running Rebels	$ 5,000.00
22	Silver Spring Neighborhood Center	$ 4,000.00
23	Summit Educational Association, Inc.	$ 4,000.00
24	Unity in Motion	$ 3,000.00
25	Wings of Glory	$ 4,000.00
	TOTAL	**$ 91,748.00**

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 8/12/13

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services (DHHS), Providing Notice of the Youth Sports Authority Award Recommendations and Approval for the Fiscal Agent to Distribute Funds

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

- ☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

- ☐ Absorbed Within Agency's Budget
- ☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A.The Director of the Department of Health and Human Services (DHHS) is requesting authorization for the Youth Sports Authority Board and its fiscal agent, Community Advocates, to distribute 2013 Youth Sports Authority funds.

B. Approval of this request will result in the distribution of $91,748 of funds to the organizations identified in the accompanying report and resolution. A total of $100,000 was appropriated for the Youth Sports Authority in the 2013 Adopted Budget of the Delinquency and Court Services Division. The fiscal agent receives an annual fee of $8,000.

C. There is no tax levy impact associated with approval of this request. The funds to be distributed come from the 2013 allocation totaling $100,000 for the Youth Sports Authority. The 2013 funds have already been transferred to the fiscal agent.

D. No further assumptions are made.

Department/Prepared By Thomas F. Lewandowski, Fiscal & Management Analyst

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CDPB Staff Review? ☐ Yes ☐ No ☒ Not Required

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justfies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE: August 26, 2013

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by: Dennis Buesing, Administrator, DHHS Contract Services

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Enter into Purchase of Service Contracts for the Operation of the Wisconsin Home Energy Assistance Program (WHEAP) in the Management Services Division

Issue

Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. Per Section 46.09, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to enter into purchase of service contracts with the Social Development Commission (SDC) and Community Advocates to operate Wisconsin Home Energy Assistance Program (WHEAP) in the Management Services Division (MSD). The contracts will follow the Federal Fiscal Year (FFY), beginning October 1, 2013 and ending September 30, 2014.

Background

The Wisconsin Department of Administration (DOA), Division of Energy Services (DES) administers statewide low income household energy assistance programs involving electric and heating bill payment assistance as well as benefits and services to assist with energy crisis situations. WHEAP serves as the umbrella program for the federally-funded Low Income Energy Assistance program or LIHEAP and the Public Benefits Program funded from fees collected through the electric utilities. LIHEAP focuses mainly on heating assistance while Public Benefits provides benefits for non-heating electric usage.

Section 16.27 of the Wisconsin Statutes governs the operation of the Wisconsin Home Energy Assistance Program (WHEAP) in the State of Wisconsin and prescribes a role for counties in delivering such assistance. Section 46.215 of the statutes specifically addresses Milwaukee County's role in providing energy assistance to eligible residents.

DHHS traditionally has sought to maintain a social service delivery system comprised of both County provided and purchased services. Partnerships with community organizations have helped DHHS make use of available community resources and expertise in carrying out its mission. For FFY13, DHHS administered $2.3 million in energy assistance subcontracts with two

community agencies resulting in assistance to 55,124 households that received $30 million in home energy assistance and 6,187 households that received $1.8 million in crisis assistance.

This program was last bid out through a Request for Proposal (RFP) process in 2011 and since that time, the contractors have successfully met performance expectations and contract requirements.

Discussion

The DHHS Director is recommending purchase of service contracts with the Social Development Commission (SDC) and Community Advocates to operate the Energy Assistance Program for Milwaukee County. Under the FFY2014 contracts, SDC and Community Advocates would continue to operate WHEAP to insure eligible households in Milwaukee County are provided with benefits and services. SDC operates three Energy Assistance sites (south, northwest and east sides of Milwaukee County) and Community Advocates currently operates one, centrally-located Energy Assistance site in downtown Milwaukee. Both agencies utilize several locations including senior/disabled housing sites, senior centers, public library facilities and community events throughout the county to process applications from within the community and promote the program. In addition, the two remaining County energy staff members have been deployed to the agencies to provide services along with their regular staff.

DHHS is recommending that a 12-month contract be awarded to SDC for $1,379,509 and to Community Advocates for $722,459 for the period of October 1, 2013 to September 30, 2014.

The 2013/2014 contract recommendations are based upon the percentage of applications processed by each agency for FFY 2013 at the time this report was prepared, as well as on the number of potential new applicants. DHHS' ability to execute these contracts will be contingent upon review and approval by the Wisconsin Department of Administration. Any contract increases received by DHHS during the course of the State DOA/DHHS contract period will be proportionately passed onto both SDC and Community Advocates.

The revenue available to fund these contracts as well as county staff and overhead costs is included in the State WHEAP contract. This State contract reflects a term of three years (FFY2013-2015) and was approved in September 2012 (Resolution File No.12-710). The WHEAP allocation for FFY14 is $2,468,327 which is $17,341 higher than the original allocation for FFY13 of $2,450,986.

Wisconsin Home Energy Program
Purchase of Service 2013-2014

Recommendation

It is recommended that the County Board of Supervisors authorize the Director of the Department of Health and Human Services, or his designee, to execute a FFY2014 contract for the period of October 1, 2013 to September 30, 2014 with the Social Development Commission (SDC) in the amount of $1,379,509 and with Community Advocates in the amount of $722,459. Further, the Director is authorized to proportionately amend the contracts upon receipt of any addenda received by Milwaukee County DHHS from the Wisconsin Department of Administration increasing the state/county contract for the operation of the WHEAP program during FFY2014.

Fiscal Impact

Each of the recommended contracts is funded with WHEAP revenue, and approval of the recommendations delineated above would have no additional tax levy impact beyond what has been allocated in the Department's 2013 Budget and 2014 Requested Budget. A fiscal note form is attached.

Respectfully Submitted,

Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board
Don Tyler, Director, DAS
Josh Fudge, Interim Fiscal & Budget Administrator, DAS
Matt Fortman, Fiscal & Management Analyst, DAS
Martin Weddle, Analyst, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff

File No.
(Journal,)

(ITEM) Report from the Director, Department of Health and Human Services, Requesting Authorization to Enter into Purchase of Service Contracts for the Operation of the Wisconsin Home Energy Assistance Program (WHEAP) in the Management Services Division, by recommending adoption of the following:

A RESOLUTION

WHEREAS, per Section 46.09 of the Milwaukee County Code of General Ordinances, the Director of the Department of Health and Human Services (DHHS) has requested authorization to enter into 2013/2014 Purchase of Service Contracts with community organizations for the Management Services Division (MSD); and

WHEREAS, based on a 2011 DHHS Request for Proposals (RFP), the DHHS Director is recommending purchase of service contracts with the Social Development Commission (SDC) and Community Advocates to operate the Energy Assistance Program for Milwaukee County for services; and

WHEREAS, each of the recommended contracts that pertains to Energy Assistance is funded with Wisconsin Home Energy Assistance Program (WHEAP) revenue, and DHHS' ability to execute these contracts will be contingent upon review and approval by the Wisconsin Department of Administration (DOA); and

WHEREAS, the 2014 funding for the agency contracts is included in the three-year (FFY13-FFY15) State WHEAP contract approved by the County Board in September 2012 (Resolution File No. 12-710); and

WHEREAS, the revenue available to fund these contracts as well as county staff and overhead costs is included in the State WHEAP contract; and

WHEREAS, the WHEAP allocation for FFY14 is $2,468,327 which is $17,341 higher than the original allocation for FFY13 of $2,450,986; and

WHEREAS, the contract recommendations are within limits of relevant 2014 State/County contracts and the 2013 Budget and 2014 Requested Budget; now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors hereby authorizes and directs the Director, DHHS, or his designee, to execute one-year contracts for the period of October 1, 2013 through September 30, 2014 with the following vendors in the following amounts:

Social Development Commission	$1,379,509
Community Advocates	722,459

TOTAL **$2,101,968**

BE IT FURTHER RESOLVED, that the Director, DHHS, or his designee, is hereby authorized by the Milwaukee County Board of Supervisors to proportionately amend both the Social Development Commission and Community Advocates contracts for the same period upon receipt of any addenda received by Milwaukee County DHHS from the Wisconsin Department of Administration increasing the state/county contract for the operation of the WHEAP program during FFY2014.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 8/26/13

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Enter into Purchase of Service Contracts for the Operation of the Wisconsin Home Energy Assistance Program (WHEAP) in the Management Services Division, by recommending adoption of the following

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. Approval of the request would permit the DHHS Management Services Division to enter into purchase of service contracts for the Wisconsin Home Energy Assistance Program (WHEAP) with the Social Development Commission (SDC) and Community Advocates. The term of the contracts would run on the federal fiscal year cycle from October 1, 2013 to September 30, 2014.

   The contract being recommended for SDC is $1,379,509 and the recommended contract for Community Advocates is $722,459.

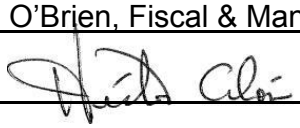
B. The revenue available to fund these contracts is included in the State WHEAP contract. The WHEAP allocation for FFY14 is $2,468,327 which is $17,341 higher than the original allocation for FFY13 of $2,450,986. The WHEAP contract also funds County staff and overhead costs. This State contract reflects a term of three years (FFY2013-2015) and was approved in September 2012 (Resolution File No.12-710).

C. There would be no tax levy impact by approving the request as the recommended contract amounts are within the WHEAP allocation.

D. The fiscal note assumes expenditures cannot exceed the amounts authorized for the purchase of service contracts.

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justfies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature 

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CDPB Staff Review? ☐ Yes ☐ No ☒ Not Required

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: August 26, 2013

TO: Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Jim Kubicek, Interim Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to release funds from the Planning Council for Individual Placement and Support (IPS) supported employment services as part of the Mental Health Redesign at the Behavioral Health Division**

Issue

In October 2012, the Department of Health and Human Services (DHHS) – Behavioral Health Division (BHD) received authority from the County Board (File 12-709) to enter into a professional services contract with the Planning Council for Health and Human Services starting November 1, 2012 through December 31, 2013 for $1,114,290 to provide specific programs related to the Mental Health Redesign Initiative. The programs included the Peer Specialist Pipeline, Step-Down Housing Alternative, Case Management Expansion, Individual Placement and Support (IPS) supported employment and Supportive Housing Units. Over the past year, BHD has received separate County Board approvals for the release of these funds by the Planning Council for each of these services.

Discussion

IPS is an evidence-based practice approach that was developed by Dartmouth University to help promote the recovery of people who have serious mental illness through competitive jobs related to their employment preferences. There have been 16 randomized controlled trials for IPS supported employment. There is strong evidence that IPS services, which emphasize a competitive employment approach, were almost three times more likely to be effective than other types of vocational services.

The following are the IPS Supported Employment Practice Principles:

- Employment specialists help people find regular jobs in the community (competitive employment).
- Every person who is interested in work is eligible for services regardless of symptoms, substance use disorders, treatment decisions or any other issue.
- Employment services are integrated with mental health treatment.

- Personalized benefits planning is provided.
- The job search begins soon after a person expresses interest in working.
- Employment specialists develop relationships with employers by learning about their business needs.
- Individualized job supports are time unlimited.
- Client preferences for jobs and preferences for service delivery are honored.

On July 22, 2013, BHD released a competitive request for proposals (RFP) seeking organizations that could sustain IPS beyond this one-time allocation for development. The RFP anticipates that agencies fully integrate the IPS model into their existing financial and organizational business model and treatment. In addition, agencies are required to develop and execute a business plan that captures and leverages other funding sources to sustain the IPS model such as Medicaid billing through Community Recovery Services (CRS). Further, the available funding of $175,000 is expected to provide support for organizational/program re-structuring, hiring and/or augmenting staff on the IPS supported employment model.

BHD anticipates identifying the successful proposer(s) in mid-September and will report this information to the Health and Human Needs Committee at its September meeting.

Pending County Board approval for the release of the IPS funds, nearly all of the $1,114,290 in Mental Health Redesign funding will be committed under contract leaving an available balance of $34,353. BHD and the Mental Health Redesign Taskforce are discussing options for use of these funds and, if needed, will return to the Board to allocate the remaining funds before the end of 2013.

Recommendation

It is recommended that the County Board of Supervisors authorize the Director of the Department of Health and Human Services, or his designee, to release $175,000 of the $1.1 million in Planning Council funds for IPS.

Fiscal Effect

There is no tax levy effect associated with this initiative. A fiscal note form is attached.

Respectfully Submitted,

Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board
Don Tyler, Director, DAS
Josh Fudge, Interim Fiscal & Budget Administrator, DAS
Matt Fortman, Fiscal & Management Analyst, DAS
Martin Weddle, Analyst, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff

File No.
(Journal,)

(ITEM *) A Resolution Requesting Authorization for the Release of Funds from the Planning Council for the Individual Placement and Support (IPS) Supported Employment Services as Part of the Mental Health Redesign at the Behavioral Health Division

A RESOLUTION

WHEREAS, in October 2012, the Department of Health and Human Services (DHHS) – Behavioral Health Division (BHD) received authority from the County Board (File 12-709) to enter into a professional services contract with the Planning Council for Health and Human Services starting November 1, 2012 through December 31, 2013 for $1,114,290 to provide specific programs related to the Mental Health Redesign Initiative; and

WHEREAS, the programs included the Peer Specialist Pipeline, Step-Down Housing Alternative, Case Management Expansion, Individual Placement and Support (IPS) supported employment, and Supportive Housing Units; and

WHEREAS, the goal of IPS is to help promote the recovery of people who have serious mental illness through competitive jobs related to their employment preferences; and

WHEREAS, there is strong evidence that IPS services, which emphasize competitive employment, were almost three times more likely to be effective than other types of vocational services; and

WHEREAS, this evidence-based approach is consistent with the goals of the Mental Health Redesign Initiative; and

WHEREAS, on July 22, 2013, BHD released a competitive request for proposals (RFP) seeking organizations that could sustain IPS beyond this one-time allocation for development and fully integrate the IPS model into their existing financial and organizational business model and treatment; and

WHEREAS, BHD is in the process of reviewing the results of the RFP process and will award a contract in mid-September; and

WHEREAS, DHHS is asking that the $175,000 in IPS funds be released now to ensure services will be available as soon as possible and funds will be expended this year; now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to allow the Planning Council to enter into an agreement with

the specified vendor or vendors for the administration of IPS for the time period of October 1, 2013 through December 31, 2013 in the amount of $175,000.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 8/26/13

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization for the Release of Funds from the Planning Council for Individual Placement and Support (IPS) Supported Employment Services as Part of the Mental Health Redesign at the Behavioral Health Division

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. The Director of the Department of Health and Human Services (DHHS) is requesting authorization to allow the Planning Council to release $175,000 in funds as part of the Mental Health Redesign Initiative in the Behavioral Health Division (BHD).

B. The total allocated for this one-time initiative is $175,000.

C. There is no tax levy impact associated with approval of this request in 2013 as funds sufficient to cover associated expenditures are included as part of the $1.1 million balance in Mental Health Community Reinvestment funds (File 12-709) authorized in October 2012 by the County Board.
Pending County Board approval for the release of the $175,000 in IPS funds, nearly all of the $1,114,290 in Mental Health Redesign funding will be committed under contract leaving an available balance of $34,353.

D. No assumptions are made.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CDPB Staff Review? ☐ Yes ☐ No ☒ Not Required

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: August 23, 2013

TO: Supervisor Peggy Romo West, Chairperson, Committee on Health and Human Needs

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Amy Lorenz, Associate Administrator, Psychiatric Crisis Services

SUBJECT: **Informational Report from the Director of the Department of Health and Human Services regarding the Community Consultation Team (CCT) at the Behavioral Health Division**

Background

The Center for Independence and Development (formerly Rehabilitation Center-Hilltop) is a Title XIX certified facility for persons with Developmental Disabilities that provides active treatment programs and an environment specially designed for residents with dual diagnoses of developmental disability and serious behavioral health conditions. In 2013, the Behavioral Health Division (BHD) has undertaken a significant downsizing of the Center for Independence and Development (CID) (formerly Hilltop). The 2014 Requested Budget continues that initiative and includes a full closure of the program by November 2014.

In an effort to support that initiative and to reduce utilization of Psychiatric Crisis Services (PCS), BHD is working to expand the Crisis Mobile Team with staff who have expertise in serving individuals who are dually diagnosed with intellectual developmental disabilities (IDD) and mental health issues. The ability to provide support during crisis situations for individuals who are relocated from the CID will be imperative to their success in the community. To best achieve a multi-disciplinary, community based approach to address the needs of individuals with intellectual developmental disabilities and challenging behaviors here in Milwaukee County, BHD has been consulting this past year with experts from the University of Wisconsin-Waisman Center. The Waisman Center is a center of excellence dedicated to the advancement of knowledge about human development, developmental disabilities, and neurodegenerative diseases. Consultants from the Waisman Center's Community TIES (Training Intervention and Evaluation Services) program have been meeting regularly with representatives from BHD and the Disability Services Division to create and design prevention and crisis intervention initiatives. The consulting work has been focused on developing a program where new supports are added to the existing community lifestyle of the individual in need of services. The additional behavioral supports being explored are:

- Ongoing behavioral expertise within community support teams
- Individualized Behavior Support Plans
- Training of positive behavior supports and pro-active crisis prevention

- Intensive safety measures added to community programs
- Environmental adaptations and modifications
- Psychiatry with developmental disabilities expertise
- Crisis response services in the community

For more information please see Attachment A - Waisman Report for Milwaukee County.

Discussion

As a result of the work with the Waisman Center and through internal discussion at BHD, the 2014 Requested Budget includes the development of a Community Consultation Team (CCT). The CCT will be a crisis mobile team that specializes in community-based interventions for individuals with both intellectual developmental disabilities and mental illness. The goal of the CCT is to provide individuals with intellectual developmental disabilities with services in the community as a way to support their community placements and thereby reduce the need for admissions to higher levels of care such as emergency room visits and hospitalizations.

The CCT will assist in the development of individualized behavioral support plans to address challenging behaviors presented by individuals in an effort to prevent the likelihood of significant behavioral and mental health crisis. Specific services available include functional behavioral assessments of clients, development of individualized behavioral support plans, staff training, assessment of facility and staff needs, consultation and support, and serving as a liaison between stakeholders, providers, and potential providers. The CCT staff will maintain on-going involvement with clients in the community and increase or decrease this involvement as needed. All of the services will be provided in collaboration with those individuals already serving the person such as case managers, housing providers, etc.

Currently, the primary focus of CCT is to provide support to individuals who are transitioning from the CID to the community. The CCT will also provide on-going crisis intervention services to individuals who have been placed in the community from the CID. As the CID closure progresses, these services will become available to all individuals in the community with intellectual developmental disabilities and mental illness who are in need of assistance.

For more information, please see Attachment B: BHD CCT Description of Services.

Staffing

In 2013, the Community Consultation Team has a dedicated Registered Nurse II and 0.5 Clinical Psychologist. In 2014, two additional clinical staff, psychology and social work disciplines will be added to the team as the CID closes.

Next Steps

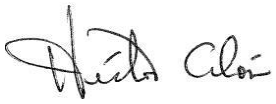
The CCT will be offering a variety of educational and support services for community providers such as Managing Threatening Confrontations and Safe Supports to Persons in Emotional and Physical Distress trainings. BHD is currently in discussions with UW-Waisman Center to select programming based upon the needs of the providers in the community and creating a training implementation program for CCT staff and service providers in Milwaukee.

The CCT, other BHD staff, and the Disability Services Division will also continue working with the UW-Waisman Center consultants and other consultants to implement system improvements of the current

service delivery system for this specific population. Some of these improvements will include ongoing behavioral consultation and support to providers, continuing to provide education programming/training, and crisis intervention services. Other possible service expansions being considered may include an outpatient clinic that provides psychiatric services for individuals with intellectual developmental disabilities and mental illness, third shift electronic monitoring of residential placements, and environmental modifications and adaptations.

Recommendation

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
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Jodi Mapp, Committee Clerk, County Board Staff

A Multi-disciplinary, Community Based Approach To Address The Needs Of Individuals With Developmental Disabilities And Challenging Behaviors

UW – Waisman Center
Community TIES

Introduction

The UW-Waisman Center has sustained a long term commitment to promote full inclusion for persons with developmental disabilities and their families. To this end a program was initiated in 1986 for those persons with DD who also present co-occurring mental health challenges. This program is titled Community TIES (Training Intervention and Evaluations Services). Over the past 28 years this program has grown in both size and level of expertise. The content and recommendations in this document are based on the experiences of Community TIES

Over the past year Waisman Center staff; Paul White and Axel Junker have committed to a series meetings with with a team of professionals coordinated by Amy Lorenz, Director of Crisis Services Milwaukee County Behavioral Health. The purpose is to determine what components of Community TIES model would be a good fit in Milwaukee County regarding positive behavior support and crisis response for people with DD.

This report represents our progress in working together to date. It is organized with this format:

- An overview of the Community TIES model where positive behavior supports are integrated into supported community programs.
- Description of seven approached that support the TIES model. Each approach in describes in this manner:
    - Who
    - Why
    - How

  Note – The seven approaches were written by a team so there is variation in writing style form one approach to the next.

- A description of how the Milwaukee County - Community Consultation Team (CCT) Is considering translating these approached into service delivery.

Overview

Supported life for persons with developmental disabilities is most effective when it promotes Full Community Membership and assures individual choice (Self Determination). Within this lifestyle most people lead overall meaningful, productive and healthy lifestyles.

Support to some people includes added attention to emotional, behavioral or psychological needs. Such needs, if unmet, are commonly termed "challenging behaviors". The community team is challenged to, on behalf of the individual, understand and meet these needs.

Understanding and meeting such needs on behalf of someone else and in this case a person with cognitive, communication or mental health challenges is most often quite complex.

Challenging behaviors can be expressed overtly (tension, emotional or physical distress) or are directed inward (withdrawal or isolation). The cause or life situation that may be stimulating the challenging behavior can be wide and varied. Included here is a list of common "stress triggers" for people with developmental disabilities. These can occur individually but are often a combination of stress triggers.

When challenging behaviors occur more often or with sufficient intensity it is not uncommon for support programs to consider moving individuals to lifestyles where safety for the individual and others is better assured. This can result in more restrictive locations where community membership and choice is limited. In doing so the supported program often only serves to increase the number of stress triggers that can result in challenging behaviors. In fact, the challenging behaviors may have been occurring because the supported living program did not offer enough choice and community involvement in the first place. This is, unfortunately, a common life dilemma for people with developmental disabilities.

A better blueprint for supporting people with developmental disabilities and challenging behaviors in the community is outlined here.

- Develop a supported living model within the County that subscribes to "best practice" standards for Full Community Membership and Self Determination.
  Apply these standards to all persons with developmental disabilities, including people who present challenging behaviors. Continue to apply resources and training to this end. Practices that are essential to this model include:

  a. Person Centered Planning and a team approach
  b. Meaningful relationships
  c. Self-Directed Services
  d. Living, working and recreating in the community
  e. Living with only a few house mates
  f. Meaningful work and recreational activities
  g. Opportunities to explore spirituality

- When challenging behaviors are of concern look first and foremost to the community support program to assure that it is truly "best practice" as described above. Continually resist pressures to move individuals to, or create, more restrictive settings.

  Develop a program within the County where additional supports can be added to the existing community lifestyle and only as much as is required. Included here are examples of gradually adding behavioral supports in an effort to assure continued supported community life:

  a. Ongoing behavioral expertise within community support teams.
  b. Individualized Behavior Support Plans
  c. Training of Positive Behavior Supports and pro-active crisis prevention
  d. Intensive safety measures added to community programs
  e. Environmental adaptations and modifications

f. Psychiatry with developmental disabilities expertise
g. Crisis Response Services in the Community

An essential component to this approach described above lies within the attitude of the community support team. The providers need to believe that the community model can and will work.

** It is noted here that this model of community support to people with DD and challenging behaviors has been developed over a 25 year period. A service delivery program should expect that the process of replicating the approaches outlined here will take time.

** Additionally all the communities in Wisconsin, while similar, can also be differentiated from one another. What is been described here as effective in Madison Wisconsin may need to be altered to best fit other community DD service delivery programs.

1. Ongoing Behavior expertise within Community Teams

What:

A significant aspect of providing positive behavioral support to individuals with developmental disabilities is proactive participation in community teams. Working together as a cohesive unit can help provide insight regarding positive behavioral support. A behavior specialist would work with the team to provide insight and direction related to supporting challenging behaviors.

Why:

Teaming around an individual with challenging behaviors is important in that it helps to ensure full community membership for the person. There are several benefits to teaming which include:

- Providing a forum to proactively address issues that may arise.
- Meeting on an ongoing basis and celebrating a person's success can help the team identify and understand what is going well and why.
- By working together in a coordinated and supportive way teams are better equipped to deal with conflicts that may arise.
- Teams that meet proactively are better able to create and update individual support plans.
- Well run teams are effective in finding resources, appropriate training, and expertise to blend mental health services within existing DD supports.
- Working proactively helps assure continued participation in supported community life.

BHD Community Consultation Team (CCT)

Consultation to community providers

- The CCT will be available to community-based providers of services to adults with developmental disabilities. Potential service recipients include providers of residential services (group homes, adult family homes, etc.), providers of day program services, and Family Care MCO Interdisciplinary Teams (IDT's). The focus of this service is on assisting in the development of intervention plans to address challenging behaviors presented by Family Care enrollees. Clinicians with extensive experience in behavior modification as well as other CCT professionals are available to work with case managers, residential staff, and others to try to problem solve around client behavioral as well as mental health issues.

2. Individualized Behavior Support Plans

What:

When a number of providers are involved in the life of the individual it is important that the "team" develop a shared vision for this support. It is suggested that the team participate in regular meetings facilitated by a professional with expertise as described above. One of the outcomes of these meetings should be a written behavior support plan (BSP).

Why:

Within a supported community lifestyle it is not uncommon for a number of providers from distinct programs to support the individual across their day/week. While the various providers will want to develop their own rapport, it is also important that there is some "thread of continuity" in the manner that each will interpret and support behavioral/mental health issues. If each provider has a different notion and approach we can inadvertently create more chaos in the life of the individual. A behavior support plan can assist in assuring this united approach across providers. Additionally there is often regular turnover in providers. The behavior support plan can effectively bridge the knowledge gap for new people coming into the life of the individual.

How:

The plan should be authored in a straightforward manner so it is easily understood by direct providers and family members. The plan should be written concisely and to the point. Use of "people first" language is recommended. Also, avoid excessive use of psychiatric/psychological terms that may not be readily understood by direct providers and could stigmatize the individual.

The behaviors specialist should guide the BSP development . Assure that best practice approaches are used. The team participation will assure that the plan is individualized.

The plan should be updated on a regular basis as individuals grow emotionally or the team learns better ways to provide support. Data collection can be part of a plan and should be straightforward and not so time intensive that it would take away time from relating to the individual.

BHD Community Consultation Team

Specific services available include behavioral assessments (functional analyses) of clients, development of intervention plans, staff training on intervention plans, assessment of facility and staff needs, staff consultation and support, and serving as a liaison between stakeholders, providers, and potential providers. The CCT will maintain on-going involvement with clients in the community increasing or decreasing this as needed. Although behavioral challenges in the community can be expected, the focus of this service is on working in a preventative manner to diminish the likelihood of significant client behavioral and mental health issues.

3. Training on Positive Behavior Supports and pro-active Crisis Prevention

What:

Training activities have long been recognized as essential to promoting quality, retaining staff, providing consistency in the provision of services, communicating best or better practices, and inspiring staff to feel good about the work they do on a day-to-day basis.

Why:

Motivated and educated staff are more likely to respond better to emergency situations, make better care decisions and exhibit more confidence in the jobs they do. Staff training builds confidence and can result in a better relationship between the service provider and the consumer, as well as providing a potential pathway to a higher degree of professional responsibility.

How:

A healthy, respectful relationship between direct care professionals and consumers has been shown to reduce critical incidents, decrease unnecessary power struggles, promote good role models and, in general, build a happier household for all.

Please see Waisman Center Training and Consultation for information on upcoming training opportunities.

BHD Community Consultation Team

Staff development services
The BHD Community Consultation Team (CCT) will offer a variety of educational and support services for community providers and their staff as well as Family Care staff. One focus of this service will be a series of educational programs designed to increase staff job-related knowledge. This includes training aimed at new staff as well as "refresher" programs for more experienced staff. Specific topics covered include the nature of developmental disabilities such as intellectual disability and autistic disorders, understanding maladaptive behavior and mental illness, and basic behavior modification techniques. Other topics could be covered as needed. The focus is on providing community staff with more tools to successfully work with adults with developmental disabilities.

A second focus of the staff development services is helping direct care providers in the community to better manage the demands associated with their jobs. While working with individuals with challenging behaviors can be quite rewarding it can also be very demanding and stressful. This aspect of the service involves offering group support to providers as well as specific programming centered around stress management and personal well-being. The focus is on preventing staff burnout and turnover and facilitating staff morale and retention.

4. Intensive Safety measures added to Community Programs

What:

For some individuals with developmental disabilities, the nature of the challenging behaviors may result in aggression, destruction or self- injury. These behaviors are sometimes expressed to a level where safety for the individual and the community is a concern. Community teams are always striving to promote positive and therapeutic community life styles that address these issues in a proactive manner. Yet, despite these efforts teams can predict dangerous behaviors will still occur. Individuals with these issues may challenge teams to develop more intensive supports to the community program in order to assure safety. The approach, then, for these individuals is to offer "best practice" supported community lifestyles while simultaneously establishing an intensive crisis response for when dangerous behaviors occur.

Why:

When these programs are effective they assure the individuals grow emotionally, keep the community safe and reduce the risk of short or long stays in more restrictive settings.

How:

Some example of intensive crisis response can include:

- Training care providers in crisis intervention strategies
- Developing a "safe space" in the home for the purposes of regaining emotional control
- Use of physical intervention
- Including the police in a coordinated crisis response.

These approaches are called "Restrictive Measures". The community support team will need to use these approaches carefully and thoughtfully in order to avoid human rights violations. Also when creating more intensive supports, teams are making decisions that may impact client rights. State of Wisconsin Community Integration Specialists should be included on the team to assist with these decisions.

BHD Community Consultation Team

The CCT will be available to consult with other providers when clients are at least temporarily unable to remain in their community residence due to behavioral or mental health issues. This would include consultation with crisis or respite service providers in the community. If the client is brought to a local emergency room or crisis service CCT staff could consult with them about the client's status. If the client is in need of acute psychiatric hospitalization at a local hospital CCT staff could be available to consult with those staff and assist in transitioning the client back to the community

5. Environmental Adaptations and Modifications

What:

Environmental adaptations and modifications come in all shapes and sizes and go beyond what one might think. People often think of ramps and other modifications to make a house more accessible when discussing this topic, but there are several other modifications that can be put in place that create a safer environment for people with aggressive tendencies. Soft furniture is sometimes a good way to prevent self-injuries, sometimes door alarms are required for those who attempt to leave their homes during times of instability when they are not safe. Reinforced windows are commonly used to prevent breakage and subsequent injury, many people who are loud during times of increased anxiety and agitation risk eviction or disturb others if rooms are not soundproofed. Even a piece of tape over a clock so an individual does not obsess over time can be an environmental adaptation.

People who become violent may require a safe room in their residence; many times these rooms are unfurnished or have soft furniture items in them to keep the person safe while she/he regains control. These rooms are not used for punishment; the person enters them voluntarily because they know they are feeling out of control and unsafe. Fencing is another modification that is sometimes added to residences, particularly for those who enjoy time outdoors but have no danger or safety awareness, or who might wander off. Fencing a yard must not take the place of staff supervision however; unknown dangers can exist in all outdoor areas and without supervision, people have been known in ingest inedible items in their yards, injure themselves on swing sets and hop over fences in attempts to explore their environments.

Why:

The impact the chosen living environment has on behavior cannot be underestimated. Many people who challenge us through their behavior have difficulty sharing personal space with anyone else and may manifest this through many means; behavioral outbursts and aggression to others are common as are competing for staff attention, intruding into others' personal space or taking items that belong to others. While modifications may risk violating residents' rights, in many cases, the person will voluntarily give up his/her rights as he/she develops insight into the destructive and dangerous nature of the behavior. Safety is one of the most important reasons for modifications and adaptations. Often an individual feels safer knowing that the doors can be locked, the stove may not turn on, and the windows are reinforced; sometimes knowing that these traditional targets "won't work anymore" actually decreases the urge for property destruction and ultimately makes the person feel safer; needless to say, staff are also feeling safer.

A final reason to implement adaptations and modifications is for the community. Individuals who can become aggressive draw attention to the home. Neighbors and the community often develop a negative impression of the individual or home based on biases, ignorance, assumptions, hearsay, and perceptions; other times, these impressions are created by the presence of police cars, loud noises, yelling or observations of conflict around the home. Minimizing these negative impressions to the

degree possible is one way for adults with disabilities to be better accepted into stable neighborhoods. Soundproofing, maintaining the yard and home to the standards of the neighborhood, and teaching boundaries will all go a long way in facilitating acceptance and helping the home to blend into the existing community.

How:

Any adaptation or modification to a person's residence must be in the best interests of the resident's health and safety and must not infringe on the rights of the person nor of others in the home. Let thoughtful, person-centered thinking be your guide; include the entire team in the discussion including the persons who will be most affected by your decision. Staff convenience should never be part of these discussions. Partner with contractors who have an understanding of what the team is attempting to accomplish with Adaptations and modifications.

BHD Community Consultation Team – The Adaption and Modification program described above is under consideration. The service will need to be different due to the Family Care Model.

6. Psychiatry with Developmental Disability Expertise

What:

The role of the psychiatrist and other medical professionals within a person's team is critical. Ensuring that objective information is shared with these professionals is one responsibility team members have when gathering to discuss "how someone is doing." Medical staff are typically trained to assess progress within one-to-one verbal communications with their patients. Working with a non-verbal client or an individual with poor or unreliable communication skills therefore requires the psychiatrist to seek objective information from that person's team in order to accurately understand dysfunctional behaviors, as well as any effects of interventions that have been tried. Successful outcomes often depend on the skill the medical professional brings to the team with respect to combining treatment models that may sometimes conflict.

Why:

Team members have the responsibility to make sure information shared with medical professionals is factual. Often times, teams may use daily log books to share progress, and though this type of information is rich with content and has great value, it is often difficult for busy professionals to look through and quickly interpret. Similarly, information presented in this way is not necessarily unbiased. Teams should strive to work towards collecting information on target behaviors/psychiatric symptoms that are well defined and related to diagnosis and interventions. Data must be collected that accurately represents how the person behaves. This information should be presented in such a way that medical professionals are able to easily read and evaluate progress in a short amount of time.

How:

Presenting data in the form of a behavioral graph allows someone to make a quick assessment, and represents a simple way for team members to share "how someone is doing." Of course, including individuals who are capable of conveying their own impressions on how a particular treatment is affecting them is important, though team members need to be certain the person's statements are reliable in order to make sure medical professionals receive accurate information. Likewise, as medical professionals often prescribe medication to assist in treating behavioral concerns, it is critical that team members work with the psychiatrist or other medical professional to clearly understand the likely benefits of any medications that are prescribed, and in this way, the data that are collected can reflect those potential benefits. If the expected benefits are not observed within a reasonable amount of time, team members should work with the medical professional to decide what the next step might be, and consider discontinuing medications that are not helpful.

BHD Community Consultation Team – *The Community TIES Psychiatric Clinic http://cow.waisman.wisc.edu/clinic.html is the Waisman Center program whose principles are described above. Dr. Steve Singer is the lead psychiatrist. Dr. Singer is committed to consulting with Milwaukee County as they consider replicating this essential service.*

7. Crisis Response Services in the Community

What:

Crisis is often defined as "the experiencing of ... a situation as an intolerable difficulty ... that exceeds the person's current resources and coping mechanisms (1)." It " ... usually refers to a person's feelings of fear, shock, and distress about the disruption, not the disruption itself (2)".

Individuals with developmental disabilities often communicate feelings that overwhelm them through "challenging behaviors" which often lead to inappropriate and costly stays in more restrictive settings (psychiatric hospitals, jail, or mental health institutions). However, "crisis" in the context of developmental disabilities services, also refers to the caregiver's perception that an individual's needs and challenges exceed the caregiver's capacity to keep the individual safe.

In a medical (and more traditional mental health) model, psychiatric hospitalizations are one of the more common responses to crisis; the goal of a short term hospitalization is the stabilization of acute symptoms (through medication adjustments) in a safe and therapeutic environment. Safety refers to both the actual quality of the environment (supervision, locked doors, etc.) but also to the patient's perception/sense of feeling safe in that environment (respite effect).

Why:

Although hospitalization can be very helpful to many individuals, it can be problematic for people with developmental disabilities:

- hospital staff might have difficulties relating to individuals with DD and their unique communication strategies
- therapeutic resources cannot easily be adapted and individualized to accommodate the learning styles of individuals with DD
- individuals with DD might not be able to transfer acquired coping skills to their home environment
- the hospital routine can be disruptive for individuals who are accustomed to a rigid, very personalized routine
- individuals with DD are more at risk to be taken advantage of by other patients and are more likely to copy unsafe coping techniques from other patients
- hospitalizations can be expensive
- hospitalizations often require the individuals to give up some control (requires Dr's permission to leave).

How:

A community-based Crisis Response system for individuals with DD strives to provide an alternative to hospitalizations. It should be:

- proactive in nature (no division between pro-active and reactive supports) and part of an ongoing outreach effort to train and prepare direct care providers for crisis intervention
- individualized and person-specific (the crisis team needs to have a thorough knowledge of the person they are serving; relationships are the key!)
- positive (anchored in the principles of Positive Behavior Support)
- consumer directed: the individual and/or his/her guardian participates in the team process and directs the development of his/her crisis plan
- easy to access at all times
- work well with existing service providers.

It should offer the following service components:

- consultation on positive behavior supports and clients rights issues (restrictive measures)
- consultation on environmental adaptations & more intensive supports/interventions
- assistance in navigating emergency mental health services (emergency detentions) and coordinating interventions with the criminal justice system
- assistance with health care coordination
- access to community-based therapeutic resources and emergency psychiatry
- access to well trained additional support staff who can assist in the assessment process, provide situational counseling, provide respite and guidance to direct care staff and support the person where he/she lives/works, or plays
- short term respite in a safe, neutral environment that is modified to accommodate behavior challenges
- follow-up consultation to prevent future crises.

A functioning crisis response system will creatively and flexibly (it's more of an art than a science) piece together additional supports on a temporary basis. It should not be considered as a permanent placement option - especially in times of dwindling public funding, but can be a cost-effective alternative to an inappropriate and lengthy institutionalization. At best, it can help individuals and their support teams to buy time, get some breathing room and hopefully contribute some ideas and instill confidence how to tweak existing supports for the better.

Crisis interventions are highly individualized: One size does not fit all. Just as individuals are different, communities are different and a model that works in one urban setting might not work at all in a rural setting, or even another urban setting. Although the key elements of crisis response might be very similar, they might be organized in very

different ways. Successful Crisis Response programs draw from the strength of existing providers and try to expand capacity starting with the resources available.

BHD Community Consultation Team

Crisis team

The BHD Community Consultation Team (CCT) will include a mobile crisis service that will be available to assist community care providers during client behavioral crises. The crisis team will be staffed with clinicians experienced in addressing behavioral issues and other staff experienced in crisis intervention. The team will work with providers to try to diffuse the crisis or help arrange for temporary alternate services (for example, respite services), if available, based upon the current needs of the client.

The crisis team is just one component of an integrated crisis system available to help address the needs of adults with developmental disabilities who are in behavioral or mental health crises. Others crisis services that may be utilized include crisis respite homes, a crisis line, BHD's Psychiatric Crisis Service (PCS) or other hospital emergency rooms, and BHD's Observation Unit. CCT crisis team staff will remain involved with the client as they transition through these various services and return to his or her community residence.

CCT staff will also be available to work with local law enforcement agencies. The focus of such involvement is on education regarding this population as well as helping officers to assist in a supportive manner when called for crisis situations in the community arising from a client's behavior.

BHD Community Consultation Team

for Individuals with Intellectual and Developmental Disabilities
June 7, 2013

Services Offered:

(1) Consultation to community providers

(2) Staff development services

(3) Crisis team

Description of Services

Consultation to community providers

The BHD Community Consultation Team (CCT) will be available to community-based providers of services to adults with intellectual and developmental disabilities. Potential service recipients include providers of residential services (group homes, adult family homes, etc.), providers of day program services, and Family Care MCO Interdisciplinary Teams (IDT's). The focus of this service is assisting in the development of individualized behavior support plans to address challenging behaviors presented by Family Care enrollees. Clinicians with extensive experience in behavior modification, as well as other CCT professionals, are available to work with case managers, residential staff, and others to try to problem solve around client behavioral as well as mental health issues.

Specific services available include functional behavioral assessments of clients, development of individualized behavior support plans, staff training on behavior plans, assessment of facility and staff needs, staff consultation and support, and serving as a liaison between stakeholders, providers, and potential providers. The CCT will maintain on-going involvement with clients in the community and increase or decrease this involvement as needed. Although behavioral challenges in the community can be expected, the focus of this service is on working in a preventative manner to diminish the likelihood of significant client behavioral and mental health crisis.

The CCT will be available to consult with other providers when clients are at least temporarily unable to remain in their community residence due to behavioral or mental health issues. This would include consultation with crisis or respite service providers in the community. If the client is brought to a local emergency room or crisis service, CCT staff can consult with them about the client's status. If the client is in need of acute psychiatric hospitalization at a local hospital, CCT staff would be available to consult with those staff and assist in transitioning the client back to the community.

Staff development services

The BHD Community Consultation Team (CCT) will offer a variety of educational and support services for community providers and their staff, as well as Family Care staff. One focus of this service will be a series of educational programs designed to increase staff job-related knowledge. This includes training aimed at new staff as well as "refresher" programs for more experienced staff. Specific topics covered include the nature of intellectual and developmental disabilities such as intellectual disability and

autistic disorders, understanding maladaptive behavior and mental illness, and basic behavior modification techniques. Other topics could be covered as needed. The focus is on providing community staff with more tools to successfully work with adults with intellectual and developmental disabilities.

A second focus of the staff development services is helping direct care providers in the community to better manage the demands associated with their jobs. While working with individuals with challenging behaviors can be quite rewarding, it can also be very demanding and stressful. This aspect of the service involves offering group support to providers as well as specific programming focused on stress management and personal well-being. The focus is on preventing staff burnout and turnover and facilitating staff morale and retention.

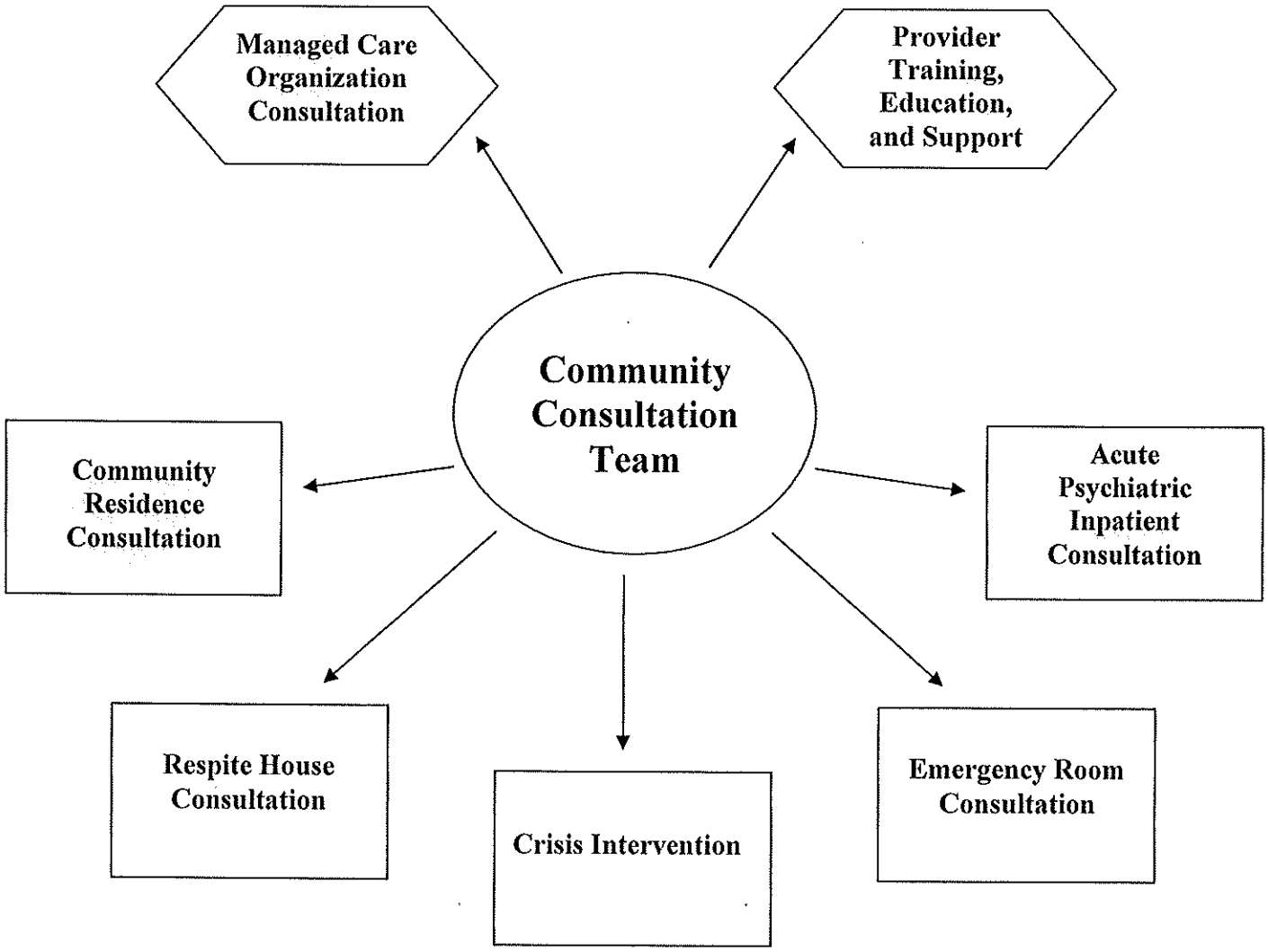
Crisis team

The BHD Community Consultation Team (CCT) will include a mobile crisis service that will be available to assist community care providers during client behavioral crises. The crisis team will be staffed with clinicians experienced in addressing behavioral issues and crisis intervention. The team will work with providers to try to diffuse the crisis or help arrange for temporary alternate services (for example, respite services), if available, based upon the current needs of the client.

The crisis team is just one component of an integrated crisis system available to help address the needs of adults with intellectual and developmental disabilities who are in behavioral or mental health crises. Others crisis services that may be utilized include crisis respite homes, a crisis line, BHD's Psychiatric Crisis Service (PCS) or other hospital emergency rooms, and BHD's Observation Unit. CCT staff will remain involved with the client as they transition through these various services and return to his or her community residence.

CCT staff will also be available to work with local law enforcement agencies. The focus of such involvement is on education regarding this population and helping officers to assist in a supportive manner when called for crisis situations in the community arising from a client's behavior.

Community Consultation Team
Service Model



COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: July 1, 2013

TO: Peggy Romo West, Chairwoman, Committee on Health and Human Needs

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Kathie Eilers, Interim Administrator, Behavioral Health Division, on behalf of the Mental Health Redesign and Implementation Task Force

SUBJECT: **From the Director, Department of Health and Human Services, submitting an informational report on the current activities of the Mental Health Redesign and Implementation Task Force**

Issue

In April 2011, the County Board of Supervisors passed a resolution (File No. 11-173) supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign and Implementation Task Force (Redesign Task Force) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities.

The Chairwoman of the Committee on Health and Human Needs requested monthly informational reporting on the activities of the Redesign Task Force.

Background

The Redesign Task Force first convened in 2011, delegating Action Teams to prioritize recommendations for system enhancements within the key areas of Person-Centered Care, Continuum of Care, Community Linkages, Workforce, and Quality. The co-chairs of the Action Teams presented their initial prioritized recommendations to the Committee on Health and Human Needs in January 2012 and at a public summit in February 2012, where consultants from the Human Service Research Institute (HSRI) provided feedback and guidance. The Redesign Task Force, its Executive Committee, and DHHS and BHD leadership resolved in March 2012 to issue a Request for Proposals for technical assistance in implementing the affirmed recommendations. DHHS entered into a professional services contract in September 2012 with a consultation team comprised of ZiaPartners, Inc., and three subcontractors.

In December 2012, the DHHS Director and BHD Administrator presented an informational report to the Committee on Health and Human Needs on the progress and activities of the Redesign Task Force, including a framework for planning, tracking, and recording progress on all redesign implementation activities, including those already accomplished or underway. The implementation activities were thereafter framed within SMART Goals – Specific, Measurable, Attainable, Realistic, and Timebound – to promote greater accountability and clearer reporting. In March 2013, the County Board of Supervisors passed a resolution (File No. 13-266) authorizing the DHHS Director to implement the initiatives outlined in the SMART Goals in collaboration with the Redesign Task Force and community stakeholders. With that authorization, the Redesign Task Force, Action Teams, and their Staff Partners are presently at work on the numerous Tactical Objectives of the SMART Goals, in pursuit of the specific Performance Targets to be achieved in 2013 and 2014.

Discussion

The Redesign Task Force convened its monthly meeting on June 5 at the Milwaukee County Mental Health Complex. The meeting featured a presentation by Mike Davis and John Hyatt on IMPACT 2-1-1 and its application to system mapping efforts by the Quality Action Team. Rob Henken also presented on the Public Policy Forum's assessment of the financial outlook for the Behavioral Health Division. Action Team leaders and their staff partners then presented updates on their respective SMART Goals.

Goal 1: A workgroup of the Person-Centered Care Action Team has reviewed the MHSIP and other widely used survey tools, discussed strengths and weaknesses of the MHSIP, consulted with Zia Partners about future satisfaction survey plans, and considered how other localities measure satisfaction and recovery outcomes. The workgroup achieved consensus that the MHSIP survey should remain in use so as not to lose the historical comparative data, but some questions may be replaced relating to key areas that are currently missing. The workgroup will also receive guidance from SAMHSA through an initiative called Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS).

Goal 3: The Workforce Action Team will reconvene in conjunction with a briefing from the Nursing's Voice project on survey results related to mental health nursing and the attitudes and interests of nursing students. The briefing was postponed from June and is expected to take place in July.

Goal 5: The Continuum of Care Action Team was designated as the Planning Workgroup for Community Recovery Services under 1915(i), and CRS implementation is being considered for approval in June by the Board of Supervisors. (This also applies to Goal 9.)

Goal 6: The System Map and Dashboard Workgroups of the Quality Action Team will receive deliverables from the TriWest Group (Zia Partners subcontractor) in June that will thereafter be adapted and improved for use by the Task Force and community partners.

Goal 8: Milwaukee County and the Milwaukee Police Department established the MPD Crisis Mobile Team. The police officer assigned to this team began orientation at BHD on June 3, and the plan is to have this interdisciplinary team begin to serve as first responders to calls for individuals who may need involuntary treatment in the month of July. This team will be able to intervene in crises in the community and help to stabilize individuals without having to complete as many Emergency Detentions. BHD Crisis Services also met with MPD on May 23 to request a renewed and increased involvement in CIT trainings. This partnership will facilitate professional relationships, spread public information on accessing crisis intervention services, and improve responses to crisis events. Also within BHD Crisis Services, there are now crisis plans on file for 350 individuals, an increase of 157% over 2012.

Goal 11: The Continuum of Care Action Team is establishing a workgroup on disability benefits advocacy to advance this goal. The group will meet June 20 and is trying to recruit more participants appropriate to the charge.

Goal 12: Four agencies received consultation from David Lynde on implementation of IPS Supported Employment: Southside Community Support Program (CSP), Easter Seals, Milwaukee Mental Health Associates (CSP), and St. Charles Youth and Family Services, a Recovery Support Coordination agency.

Goal 13: Pathways To Permanent Housing officially opened on June 3. This transitional housing options will allow individuals to transition out of more restrictive settings and will also add a housing option for those who may be at risk of being homeless. The Housing Division is also in the process of proposing a new scattered site permanent housing program for 2014. These units will be seen as an alternative to CBRF placements as well as the project-based permanent supportive housing developments. The Housing Division has published the application for Housing For Healthy Initiatives. The deadline to respond for agencies is June 24, and funds will be committed in July. These funds can be used for

acquisition and/or rehabilitation of housing units for individuals aging out of the foster care system and participating through Wraparound's O-YEAH program.

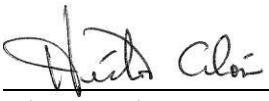
After being established at the May 8 Task Force meeting, the Cultural Intelligence Action Team met for the first time on June 11 and will subsequently focus on a Cultural Intelligence Action Plan, cultural intelligence training, mapping cultural diversity data and statistics, and growing and sustaining an interpreter/translator network.

The technical assistance contract with Zia Partners will conclude at the end of June, about one month ahead of schedule. The decision to end the contract was made in light of the recent progress of the Redesign Task Force, which is now well equipped to carry out the implementation of the SMART Goals and related initiatives. Staff and stakeholders are grateful to Zia Partners and their subcontracted consultants for the assistance they have provided since September 2012.

The next meetings of the Redesign Task Force are July 10 and August 7. County officials and any other interested parties are encouraged to visit the website that has been designed to house resources and updates related to redesign activities, including a meeting schedule for the Redesign Task Force and Action Teams. The site is http://county.milwaukee.gov/MHRedesign.htm. Comments or inquiries about redesign activities may be directed to David Johnson at 414-257-5255 or david.johnson@milwcnty.com).

Recommendation

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board
Don Tyler, Director, DAS
Josh Fudge, Interim Fiscal & Budget Administrator, DAS
Matt Fortman, Fiscal & Management Analyst, DAS
Jodi Mapp, Committee Clerk, County Board Staff

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: August 16, 2013

TO: Peggy Romo West, Chairwoman, Committee on Health and Human Needs

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Jim Kubicek, Interim Administrator, Behavioral Health Division, on behalf of the Mental Health Redesign and Implementation Task Force

SUBJECT: **From the Director, Department of Health and Human Services, submitting an informational report on the current activities of the Mental Health Redesign and Implementation Task Force**

Issue

In April 2011, the County Board of Supervisors passed a resolution (File No. 11-173) supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign and Implementation Task Force (Redesign Task Force) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities.

The Chairwoman of the Committee on Health and Human Needs requested monthly informational reports on the activities of the Redesign Task Force.

Background

The Redesign Task Force first convened in 2011, delegating Action Teams (AT) to prioritize recommendations for system enhancements within the key areas of Person-Centered Care, Continuum of Care, Community Linkages, Workforce, and Quality. The AT co-chairs presented their initial prioritized recommendations to the Committee on Health and Human Needs in January 2012 and at a public summit in February 2012, where consultants from the Human Service Research Institute (HSRI) provided feedback and guidance. The Redesign Task Force, its Executive Committee, and DHHS and BHD leadership resolved in March 2012 to issue a Request for Proposals for technical assistance in implementing the affirmed recommendations. DHHS subsequently contracted with a consultation team comprised of ZiaPartners, Inc., and three subcontractors from September 2012 through July 2013.

In December 2012, the DHHS Director and BHD Administrator presented an informational report to the Committee on Health and Human Needs on the progress and activities of the Redesign Task Force, including a framework for planning, tracking, and recording progress on all redesign implementation activities, including those already accomplished or underway. The implementation activities were then framed within SMART Goals – Specific, Measurable, Attainable, Realistic, and Timebound – to promote greater accountability and clearer reporting. In March 2013, the County Board of Supervisors passed a resolution (File No. 13-266) authorizing the DHHS Director to implement the initiatives outlined in the SMART Goals in collaboration with the Redesign Task Force and community stakeholders. With that authorization, the Redesign Task Force, ATs, and their Staff Partners are presently at work on the numerous Tactical Objectives of the SMART Goals, in pursuit of the specific Performance Targets to be achieved in 2013 and 2014.

Discussion

The Redesign Task Force convened its monthly meeting on July 10 at the Milwaukee County Mental Health Complex. The meeting featured a presentation by Nathan Zeiger (Executive Director, Bell Therapy) on the mission and activities of the Milwaukee Co-Occurring Competency Cadre, as they relate to Redesign Task Force initiatives. The Action Team (AT) co-chairs presented on their progress toward the SMART Goals.

Goal 1: A workgroup of the Person-Centered Care AT is drafting a preface for the MHSIP survey tool and revising the survey to be more appealing and user-friendly. Aurora representatives have shared their survey tools with the group for comparison and discussion. The group is also working with BRSS TACS (SAMHSA initiative) to improve the presentation of the MHSIP survey. The AT indicated it would rely on the Quality AT and its workgroups to capture personal stories of change, which they assess the MHSIP as failing to do.

Goal 2: A second workgroup of the Person-Centered Care AT met in July to develop a curriculum for public education sessions to be held in each Supervisory District. The AT is working with Rogers InHealth and the Wisconsin Initiative for Stigma Elimination (WISE) to recruit individuals willing to share their personal stories. InHealth has short videos of personal stories that may be used if there is no one available or willing to speak in a particular district. The sessions may feature pieces of art, and the AT co-chairs raised the idea of a partnership with Grand Avenue Club.

Goal 4: BHD Community Services worked with Mental Health America to create a Peer Pipeline website, which will be regularly updated with information on training, certification exams, continuing education opportunities, and other resources for current and prospective Peer Specialists. MHA hosts and maintains the site at http://www.mhawisconsin.org/peerpipeline.aspx.

Goal 5: The County Board authorized BHD to implement the Community Recovery Services psychosocial rehabilitation benefit under 1915(i) (also part of Goal 9). BHD is also utilizing the services of BSG and consultant Peter Garner to look internally at what the County should be doing in preparation for full implementation of the Affordable Care Act and how to create a "business plan" for long-term viability and maximization of resources. BSG has done similar analyses for Aurora, Wheaton Franciscan, and Columbia St. Mary's.

Goal 6: The TriWest Group provided its final deliverable to the Quality AT, including a system dashboard concept, a broad system map, and a dashboard for SMART Goal progress tracking. The AT and three workgroups will now adapt these tools to be useful to the redesign efforts and the system as a whole.

Goal 12: Consultant David Lynde continues to work with the agencies committed to implementing the IPS Supported Employment model. The Community Linkages AT assisted in developing an RFP for infrastructure development for the IPS model. The RFP was opened on July 22, and proposals were to be received by August 16. The Community Linkages AT has also compiled a list of local agencies providing employment support for persons with mental illness and substance use disorders. The list is not yet complete but is included on the Mental Health America website and will be updated.

Goal 13: Following an RFP for housing for persons aging out of foster care, the Housing Division will work with Journey House to implement a comprehensive plan for the Clarke Square neighborhood, including housing and job training. Pathways to Permanent Housing held an open house on July 25.

Goal 16: The Cultural Intelligence AT established subcommittees to address specific components of its SMART Goal and Tactical Objectives.

The technical assistance contract with Zia Partners concluded in June.

The Redesign Task Force did not meet in August, and its next meetings are September 4 and October 2. County officials and any other interested parties are encouraged to visit the website that hosts resources and updates related to redesign activities, including a meeting schedule for the Redesign Task Force and Action Teams. The site is http://county.milwaukee.gov/MHRedesign.htm. Comments or inquiries about redesign activities may be directed to David Johnson at david.johnson@milwcnty.com.

Recommendation

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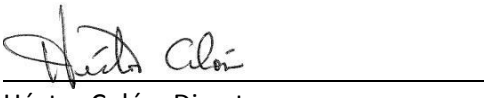

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Jodi Mapp, Committee Clerk, County Board Staff